GATEWAY REGIONAL SCHOOL DISTRICT

Blandford Chester Huntington Middlefield Montgomery Russell
12 Littleville Road, Huntington, MA 01050

School Year 2026-2027

Student Health Information Form

Student Name: _____ Date of Birth:_____Grade:_____

Preferred Name: _____Preferred Pronouns:_____

Parents/Guardians Names: _____

Child lives with: _____

Language(s) spoken at home: _____

Address: _____Town/Zip: _____

Student's Cell#:_____(Optional) Parents will be notified prior to calling a student's cellphone. Text not utilized.

Emergency Contacts

Please list parent/ guardian and 2 other responsible adults who may pick up your child

1st Name:	**Relationship**	**Phone #**
2nd Name:	**Relationship**	**Phone #**
3rd Name:	**Relationship**	**Phone #**

Medical Information

Student health conditions:_____
Please list any allergies:_____

Please list any medications currently being taken at home:_____

Does he/she need medication at school? ❑ YES or ❑ NO Name of Medication: _____

Does your child have a Special Individualized Health Care Plan: ❑ YES or ❑ NO
Is your child enrolled at the School Based Health Center: ❑ YES or ❑ NO

Please indicate if your child has the following diagnosis:
Life Threatening Allergy ❑ YES or ❑ NO / EpiPen prescribed: ❑ YES or ❑ NO
Life Threatening Allergy to:_____
Asthma ❑ YES or ❑ NO / Uses Rescue inhaler ❑ YES or ❑ NO
Seizures ❑ YES or ❑ NO
Diabetes ❑ YES or ❑ NO **Depression/Anxiety** ❑ YES or ❑ NO **ADHD/ADD** ❑ YES or ❑ NO
Cardiac Conditions ❑ YES or ❑ NO/ Specify:_____
Hearing Difficulties (Please Specify)_____**Vision Problems** (Please Specify)_____
Other : _____

Please send the **Medication Order** and **Emergency Action Plan** (if applicable) to the nurse before school starts. New orders are required each school year. Nurse private fax phone# HS/MS: 413-667-3048, Chester: 833- 284-9093 Littleville: 833-259-4133 Children with inhalers or EpiPens, if deemed appropriate by the prescribing provider can self-administer, please have the provider indicate that on the medication order. Example: "Can carry and self-administer". For all other medications, they must be brought in by a parent/guardian in their manufacturer labeled container, no more than a 30 school day supply. In addition to the above, a consent form for administration must be signed in accordance with state regulation 105CMR210.00. Medications can be retrieved on the last day of school by end of school day. Medications not collected will be destroyed.

** TURN OVER TO COMPLETE OTHER SIDE **

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Student Name:_____ Date of Birth:_____

I give my permission to the school nurse to administer the following over-the-counter medications to my child, according to established protocols, as indicated by my signature below.

Acetaminophen (Tylenol)	YES	NO	
Ibuprofen	YES	NO	
Calagel (Anti-itch gel)	YES	NO	
Burn Spray	YES	NO	
Eye Wash Solution	YES	NO	
Wound Wash	YES	NO	
Petroleum Jelly (Vaseline)	YES	NO	
Hand Sanitizer	YES	NO	
Sunscreen SPF 45 or greater	YES	NO	
Hand lotion no fragrance	YES	NO	
Albuterol (Emergency)	YES	NO	
Narcan (Emergency)	YES	NO	
Epinephrine aka EpiPen (Emergency)	YES	NO	
Diphenhydramine (Benadryl)	YES	NO	
Cough Drops (Grades 6-12)	YES	NO	N/A

- I understand I may call the school nurse for more information.
- To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent/Guardian Signature: _____ Date: _____
All other medications require a written MD order, parental permission & Medication Administration Plan

In case of an emergency, the school will attempt to contact a parent/guardian before calling a student's primary care provider. If necessary, your child will be transported by ambulance to an emergency care facility.

- I give permission for the school nurse to share relevant health information with my child's health care provider for referral, diagnosis or treatment for this school year. _____(Initial here)
- I give permission to my child's doctor _____ to release to the school nurse information which they believe to be in the best interest of my child. _____(Initial here)
- I give my permission to the school nurse to share information relevant to my child's health with appropriate school personnel. _____(Initial here)
- I give my permission for the school nurse to share this form with emergency responders in the event of an emergency as well as to treat and transport my child to a hospital if I am unable to be reached. _____(Initial here)
- My signature below attests that the information on this form is correct. Should any changes occur, I understand that I am responsible for notifying the school nurse. I have read, understood, and completed this form to the best of my ability. I understand that I may contact either school nurse at any time with questions, concerns, or updates.

Parent/Guardian Signature: _____ Date: _____
Primary Care Provider: _____Phone:_____
Dentist:_____Phone:_____
Medical Insurance Provider: _____Insurance group/certificate #:_____
Additional Community Providers:_____Phone:_____
(Please Circle one) Private Health Insurance / Public Health Insurance/ No Insurance

** TURN OVER TO COMPLETE OTHER SIDE **