Valley Collaborative
Health Office
40 Linnell Circle Billerica, MA 01821 * Tel: (978)-528-7800 * http://www.valleycollaborative.org

Dear Parents/Guardians,

Welcome to the 2026-2027 school year at Valley Collaborative! Please find our health forms enclosed. Every year we require new forms to be filled out so we can ensure that we have up to date parent/guardian contact information, medication, and any other changes that may have occurred in the past year. Our number one goal is the safety of our students. If information changes throughout the school year, please notify your school nurse.

If your student requires medications during the school day or has a special medical condition such as allergies, or seizures please contact the health office at your child's school as additional forms may be required. All physicians' orders to administer medication during school hours should be renewed for the 2026-2027.
school year.

- Please be aware that the *Parental Permission for Standing Orders* form must be signed by a parent or guardian for the nurse to administer any of the over-the-counter medications such as Tylenol or Advil.

- Up to date *Immunization records* are required to be on file in the health office. Please notify your school nurse when a new immunization is given in writing via immunization record.

- *Physicals* are required within the first year of enrollment and every year thereafter

All medical forms included in this packet are required by the Mass. Dept. of Public Health. The Massachusetts school physical record and immunization record sheets are attached in this packet. Contact your student's school nurse if you are unsure the status of your child's records.

All forms should be sent to your student's school health office. Do not hesitate to call the health office with any questions. Completed packets must be returned prior to the start of the summer program.

Stay Healthy,

Jessica Marcotte BSN, RN, NCSN
Valley Collaborative Lead Nurse
978-528-7896
Jessica.marcotte@valleycollaborative.org

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EMERGENCY MEDICAL INFORMATION

School Year 2026-2027

Student's Name:_____Date of Birth: _____ Gender: _____

Address:_____Town/City: _____ State/Zip: _____

Contact #1 -Parent/Guardian Name:_____Relationship: _____

Address:_____

Email Address:_____

☐ Home phone#:_____

☐ Work phone#:_____

☐ Cell phone#:_____

Contact #2 -Parent/Guardian Name:_____Relationship:_____

Address:_____

Email Address: _____

☐ Home phone#:_____

☐ Work phone#:_____

☐ Cell phone#:_____

Emergency Contact (if parents cannot be reached) -Name:_____

Telephone#:_____Relation to student:_____

(Please use back of form if more room is needed.)

Does your child wear glasses? ☐ Yes ☐ No Any other assisted devices? _____

Allergies/Asthma: ☐ yes ☐ no (If yes, please list below) **(Nurse use only:** ☐ **Asthma/Allergy Action Plan in Place)**

Allergy/Asthma	Describe Reaction	Treatment

(Please use back of form if more room is needed.)

Seizure Activity: ☐ yes ☐ no (If yes, please describe): **(Nurse use only:** ☐ **Seizure Action Plan in Place)**

Describe Seizure	Treatment

Medical/Social/Emotional/Mental Health Diagnoses:

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Student's Name:_____Date of Birth:_____

Medication (Please list *all* medication taken by student. Medications taken at school require a physician's order)

Medication Name	Dosage	Frequency	Time Taken	Reason for Medication

Dietary restrictions or feeding concerns:

_____

_____

Insurance Information (to be used in the event of emergency hospitalization):

Insurance Company:_____Policy#:_____

Policy Holder: _____

Medical Specialists

Primary Care Physician: _____Telephone#:_____Fax#:_____

Dentist:_____Telephone#:_____Fax#:_____

Psychiatrist_____Telephone#: _____Fax#:_____

Other:_____Telephone#:_____Fax#:_____

EMERGENCY MEDICAL TREATMENT CONSENT

I understand that in the case of a Medical Emergency, requiring treatment or hospitalization, student will be taken to the nearest treatment facility and given all lifesaving measures, unless otherwise indicated.

Parent/ Guardian Signature: _____ Date: _____

RELEASE OF RECORDS

I give Valley Collaborative my permission to exchange medical information with the individual's medical team and/or sending school for the purpose of sharing pertinent information necessary for proper treatment.
Any information obtained by Valley Collaborative will be held in the strictest confidence.

Parent/Guardian Signature:_____Date:_____

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Student's Name:_____Date of Birth:_____

PARENTAL PERMISSION for STANDING ORDERS

Nurses may administer the following over the counter medication as needed with parental/guardian permission. Please draw a line through any item you do not want given.

1. Acetaminophen (Tylenol) every 4 hours for complaint of pain or fever over 100.5 degrees.
   Dosage: Under 25lbs. give 10mg. per 2lbs. 30-40 lbs. give 160mg. 41-60lbs. give 240mg.
   Over 60lbs give 325- 650mg. Not to exceed 4g/day
2. Ibuprofen (Motrin/Advil) every 6 hours for complaint of pain or fever over 100.5.
   Dosage: Child 6 mo.-12 yrs 5mg/kg. Child over 12 yrs 200-400mg. Not to exceed 3.2g/day
3. Oral pain reliever for tooth pain or mouth sores as needed.
4. Calcium Carbonate antacid (Tums) for indigestion up to 2 tabs for one dose only.
5. Diphenhydramine (Benadryl) every 4 hours as needed for *allergic reactions: itching, and/or hives.*
   Dosage: Child under 50lbs. give 12.5 mg (5cc) Child over 50lbs. give 25mg (10cc)
6. Cough drops as needed for throat discomfort/cold symptoms.
7. Caladryl as needed for itch.
8. Hydrocortisone 1% as needed for itch
9. Hand Sanitizer up to 70% alcohol, I pump dispersed in hands

***Items that may be carried by student during school hours only after nurse consultation.**
Supplies must be provided by the family:

1. Rescue Inhaler: Must be accompanied by an MD order and Asthma Action Plan
   Dosage: as prescribed by MD
2. Enzymes: must be accompanied by an MD order
   Dosage: as prescribed by MD
3. Diabetes testing supplies and Insulin: must be accompanied by an MD order and Diabetes treatment plan.
4. Epi-Pen: must be accompanied by an MD order and Allergy Action Plan

Dosage and administration for anaphylactic reaction, laryngeal edema, or hives:

Preschool: 0.1ccIM or SC
Elementary/Middle School: 0.15cc IM or SC (weight less than 50lbs.)
High School/Adult: 0.3cc IM or SC (weight greater than or equal to 50lbs.)
**Repeat injection in 5-15 minutes if the child's condition has not improved/deteriorated and EMS has not arrived yet.
Heart rate must be less than 180 beats per minute.*

Parent/Guardian Signature:_____Date:_____

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PHYSICIANS MEDICATION ORDER FORM

Name of Student:_____ Date of Birth: _____

Address:_____ Telephone _____

Physician/Clinic:_____ Telephone _____

Allergies/Adverse medication reactions: _____

MEDICATIONS TO BE GIVEN DURING SCHOOL HOURS

Date	Medication & Dose	Route & Frequency	Treatment Purpose	Special instructions (Including parameters for vital sign monitoring, if needed)	Duration/Stop Date

Unless indicated by Physician, above medications may be administered by trained staff.

Physicians Signature:_____Date:_____

Parental/Guardian Signature: _____Date_____

☐ I consent to have the program nurse or trained school personnel designated by the program nurse administer prescribed medication to my student.

☐ I give my permission for student to self-administer medication/self-treat, if the program nurse determines it is safe and appropriate.

☐ I give permission to the program nurse to share information relevant to the prescribed medication/treatment administration as he/she determines appropriate for student's health and safety.

The school may only hold a thirty-day supply of medication and that medication must be delivered to the program nurse by a parent/guardian or sent with student in a locked box provided by the family

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SUNSCREEN & INSECT REPELLANT APPLICATION AUTHORIZATION FORM

Dear Parent(s)/Guardian(s):

Valley Collaborative policy does not permit school personnel to purchase sunblock or insect repellant for the students. Parents are encouraged to apply sunblock prior to leaving for school in the morning and to send additional product for the student to self-apply later in the day as needed. If your child cannot apply their own sun protection without assistance, staff may assist with sunblock sprays or sticks, but not lotions or wipes. **If there is a reason your child's sunblock must be in a cream form and he/she requires assistance, the nurse may apply it with a note from you, explaining why it is necessary.**

Please label your child's sunblock with their name and instruct them to keep it handy in their school bag. If you feel the student cannot be responsible for their own sunblock please contact the nurse to make other arrangements. Students can NOT share sunblock or bug spray. The same policies apply for applying and storing bug spray as they do for sunscreen.

If you have any questions or concerns regarding this notice, as always please feel free to contact your school nurse at the phone number or email below.

Sincerely,

Jessica Marcotte BSN RN NCSN
978-528-7896

SUNSCREEN & INSECT REPELLANT APPLICATION AUTHORIZATION FORM

I, _____, hereby give my permission for Valley Collaborative staff to

assist my student, _____ in the application of: ☐ Sunscreen ☐ Insect Repellant

I understand that I must supply the sunscreen and/or insect repellant for my student.

_____ _____

Parent/ Guardian Signature Date

Building a community that empowers children and adults to find their own way.

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth: _____
Medical History _____

Pertinent Family History

Current Health Issues

Y **N**

☐ ☐ Allergies: Please list: Medications _____ Food _____ Other _____
History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: _____

☐ ☐ Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** _____

Hgt: _____ (_____%) Wgt: _____ (_____%) BMI: _____ (_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other _____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: _____; Results: _____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: _____

☐ Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** _____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth: / / Sex: M F**

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date: / /**

Signature:

Facility name: