

Newburyport Public Schools
CONFIDENTIAL NEW STUDENT HEALTH INFORMATION

STUDENT:

Last Name First Name Middle Name Date of Birth Grade

Primary Contact in the event of an emergency during school hours:

Contact #1: _____ Relationship: _____ Phone: _____

Contact #2: _____ Relationship: _____ Phone: _____

Health/Medical Conditions: Please check all that apply

☐ ADHD/ADD	☐ Cardiac Conditions	☐ Gynecological/Menstrual Issues
Allergies ☐ Bees ☐ Food ☐ Lactose ☐ Latex ☐ Medication ☐ Gluten List Allergies/Intolerances: _____ Epi-pen Self-carries? ☐ Yes ☐ No ☐ Yes ☐ No	☐ Celiac Disease	☐ Hearing Impairment
	☐ Cancer: type _____	☐ Inflammatory Bowel Disease (Ulcerative Colitis, Crohn's, etc)
	☐ Cerebral Palsy	☐ Kidney Disease
	☐ Constipation or Encopresis	☐ Lupus
☐ Anxiety	☐ Cystic Fibrosis	☐ Lyme Disease ☐ Acute or ☐ Chronic
☐ Asthma (current or history) or Breathing (Respiratory) Disorder If yes, used asthma medication within the past two years? ☐ Yes ☐ No Self Carries Inhaler ? ☐ Yes ☐ No	☐ Depression	☐ Migraine Headaches
☐ Arthritis	☐ Diabetes Type I Insulin by _____ ☐ Pump or ☐ Injection CGM ☐ Yes ☐ No CGM type: _____	☐ Neuromuscular Degenerative Disorder
☐ Autism Spectrum Disorder	☐ Diabetes Type II	☐ Nose Bleeds
☐ Autoimmune Disorder: _____	☐ Difficulty communicating pain	☐ PTSD/Trauma History
☐ Blood Dyscrasias: ☐ Anemia ☐ Hemophilia ☐ Sickle Cell Trait ☐ ITP ☐ Von Willebrand ☐ Other	☐ Dizziness/Fainting	☐ Pulmonary Hypertension
☐ Other Behavioral Health Condition: _____	☐ Ear Infection/Tubes	☐ Seizure Disorder
	☐ Eating Disorder	☐ Skin Rashes
	☐ Frequent Urination	☐ Spina Bifida
	☐ Other Neurological Condition: _____	☐ Thyroid Problems
		☐ Visual Impairment
		☐ Other Physical Condition: _____

Please provide additional details on health conditions that may require nursing services during the school day:

☐ **Uses adaptive equipment:** hearing aids, sound field amplifiers, wheel chair, or crutches (list) _____

☐ **Takes daily medication (list Name, Dose, Frequency):** _____

Other information you would like to share about your child's health?

Health Provider Information

Physician	Last Name	First Name	Phone	None	Health Insurance ☐ Yes ☐ No
Dentist	_____	_____	_____	☐	Provider _____
	_____	_____	_____	☐	Policy # _____

Permission

☐ Information on this form may be shared with appropriate school personnel in order to meet my child's safety and healthcare needs, and school nurse may communicate with medical provider for the purpose of diagnosis, treatment, and referral.

Parent/Guardian Name

Parent/Guardian Signature

Date