



Ayer Shirley Regional School District

Health and Emergency Information SY26-27

Student Name: _____ Teacher: _____ Grade: _____

Please circle the school your child attends: HS MS PH LAW

Over-the-counter (OTC) medications are drugs that do not require a prescription in order for you to purchase them. In the school system, physician orders are required in order to administer OTC medications in the health office. Our school physician has written standing orders for the medications listed below. OTC medication will be given based on our current standing orders. *This parental consent form is required before any OTC medication can be administered at school.*

*****PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION*****

_____ Hydrocortisone Cream 1%
_____ Eye Saline Solution
_____ Vaseline or Aquaphor
_____ Caladryl or Calamine lotion
_____ Antacid Tablets (Tums)
_____ Orajel

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil, Motrin)
_____ Diphenhydramine (Benadryl)
_____ Cetirizine hydrochloride (Zyrtec)
_____ Aloe Vera gel

Your child's doctor: _____ Phone: _____
Your child's dentist: _____ Phone: _____
Your child's eye doctor: _____ Phone: _____

Medical Insurance (Please check):

Children's Medical Security Plan _____ Mass Health _____ Private Insurance _____

If your child needs health insurance please reach out to your child's school nurse for assistance.

Medical History

Please list ALL conditions that your child is currently being treated for?

Does your child have the following conditions?

Asthma _____ (Inhaler & Asthma Action Plan needed every school year)

Please explain _____

Food Allergies _____ (Epipen & Allergy Action Plan needed every school year)

Please explain _____

Stinging Insect Allergy _____ (Epipen & Allergy Action Plan needed every school year)

Please explain _____

Other allergies: Specify reaction and treatment _____

Does your child wear eyeglasses? YES _____ NO _____
Does your child have hearing loss? YES _____ NO _____
Has your child been diagnosed with scoliosis? YES _____ NO _____

When was your child's last physical exam? _____ (please provide a copy to the nurse if you haven't done so already)

Does your child take any medication on a regular basis? If yes, for what reason? List medication(s):

1. Medication _____ Reason _____
2. Medication _____ Reason _____
3. Medication _____ Reason _____

SCHOOL-BASED HEALTH SCREENINGS

Please **initial next to each screening** for which you **give permission** for your child to participate. If no screenings are initiated, your child will not participate in the selected school-based health screenings.

- _____ **Vision Screening** (Grades PreK–5, 7, & 10)
_____ **Hearing Screening** (Grades K–3, 7, & 10)
_____ **Height, Weight & BMI Screening** (Grades 1, 4, 7, & 10)
_____ **Postural Screening** (Grades 5–9)
_____ **SBIRT Screening** – *Screening, Brief Intervention, and Referral to Treatment* (Grades 7 & 9)

If your child receives any immunizations during the school year, please provide updated documentation to the school health office so that your child's health record can be updated accordingly. Please note that physician offices do not routinely send physical examination reports or immunization records directly to schools. It is the parent/guardian's responsibility to submit all updated health and immunization documentation to their child's school.

Initial : _____

If your child experiences any changes in their health status, medical condition, medications, or treatment plan during the school year, please notify the school nurse as soon as possible. Healthcare providers do not routinely communicate these changes directly to schools. It is the parent/guardian's responsibility to ensure that the school receives updated health information so that appropriate care and support can be provided during the school day.

Initial : _____

I understand that the information contained in my child's school health record is confidential. However, federal and state laws allow relevant health information to be shared with school personnel who have a legitimate educational or health-related need to know, as well as with individuals who may be required to assist during a medical emergency. In all other circumstances, my written consent will be obtained prior to the release or disclosure of health information, unless otherwise permitted by law.

Initial : _____

Parent/Guardian's Signature _____ Date _____