Dudley-Charlton
REGIONAL SCHOOL DISTRICT
68 Dudley-Oxford Road
Dudley, MA 01571

Phone: (508) 943-6888
Fax: (508) 943-1077
www.dcrsd.org

STUDENT HEALTH INFORMATION SHEET

MUST BE COMPLETED AND SIGNED ANNUALLY

Student name:_____Date of Birth:_____ ☐ Male ☐ Female

School name:_____Grade: _____

Family Doctor/Practice:_____Phone number: _____

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

Contact #1:_____Phone:_____ Relationship:_____

Contact #2:_____Phone:_____ Relationship:_____

Contact #3:_____Phone:_____ Relationship:_____

Student Health Information (PLEASE FILL OUT COMPLETELY)
All health information is considered confidential. It may be shared with staff as needed during the time your child is enrolled in the Dudley-Charlton Regional School District in order to ensure the health and safety of your child.

Health/Medical History:_____

Allergies:_____

Hearing/vision (tubes, hearing aids, glasses, contacts, etc.): _____

Daily Medications (list name, dose & frequency):_____

Potential life threatening conditions:

- Severe allergy (requiring emergency medication):_____
  Reaction: _____
- Seizure disorder: ☐ yes ☐ no Date of last seizure: _____ Emergency medication: ☐ yes ☐ no
- Severe asthma (regularly takes medication): ☐ yes ☐ no Emergency medication: ☐ yes ☐ no
- Diabetes: ☐ yes ☐ no Emergency medication: ☐ yes ☐ no
- Other:_____

Medication consent:

☐ I give permission for the school nurse to administer over the counter medications included in the DCRSD district orders.

(Tylenol, Motrin, Benadryl, Zyrtec, Tums, Calamine lotion, Hydrocortisone, Neosporin, Bactine, Bacitracin, Sterile eye irrigation, Burn gel, Anbesol/ Orajel, Vaseline, cough drops, Callergy lotion, Lactaid, Sting wipes, Antiseptic wipes, Biofreeze)

To **decline** specific medications for your child**, please list:**

_____

_____

Signature of parent/guardian:_____**Date:**_____