

Emergency / Medical Form

PLEASE PRINT

Date: _____

Student Last Name _____ **First Name** _____ **Grade** _____

Address _____
Street and Apt. # _____ City _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____
Month / Day / Year

In case of an emergency, parent / guardian can be reached at: Home Yes No Work Yes No

Mother's Name _____ Cell Phone: _____

Mother's Address: _____ Home Phone: _____
Street and Apt. # _____ City _____ Zip Code _____

Mother's Place
Of Work _____ Work Phone _____

Father's Name _____ Cell Phone: _____

Father's Address: _____ Home Phone: _____
Street and Apt. # _____ City _____ Zip Code _____

Father's Place
of Work _____ Work Phone _____

Legal Guardian's Name _____ Cell Phone: _____

Legal Guardian's Address: _____ Home Phone: _____
Street and Apt. # _____ City _____ Zip Code _____

Legal Guardian's Place
of Work _____ Work Phone _____

Two neighbors or nearby relatives who will assume temporary care of your child when you cannot be reached:

1. Name _____ Cell Phone: _____
Address: _____ Home Phone: _____
Street and Apt. # _____ City _____

2. Name _____ Cell Phone: _____
Address: _____ Home Phone: _____
Street and Apt. # _____ City _____

Other Individuals to authorized to pick-up your child:

Signature required please continue to Reverse Side → → → → → → → →

Parent Permission – and health information:

During the school year, in case of accident or serious illness, I/we request the school make every effort to contact me/us first.

If the school is unable to reach me/us, I/we hereby authorize the school to call the doctor indicated below and to follow his/her instructions. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

If it is not possible to contact the doctor, the school may make whatever arrangement that seems necessary due to the circumstance at hand.

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.

Mother's Signature _____ **Date** _____

Mother's Printed Name: _____

Father's Signature _____ **Date** _____

Father's Printed Name: _____

Legal Guardian Signature _____ **Date** _____

Legal Guardian Printed Name: _____

If you do not have health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

Health Care Information: Does the student have: Medicaid: Freecare: Private Health Insurance: No Insurance:

Doctor's Name: _____ **Phone #:** _____

Doctor's Address: _____

Dentist's Name: _____ **Phone #:** _____

Address: _____

Please note any diagnosed **drug/food allergies** or other complicating factors an emergency room doctor should be aware of prior to treating your child:

Please note any **current medications taken at home or in school** an emergency room doctor should be aware of prior to treating your child:

If your child is in daycare, please provide the following:

Daycare provider : _____ Before School After School:

Address: _____ Phone #: _____

If at any time this information changes, please notify the school immediately.