EMERGENCY CONTACT / MEDICAL INFORMATION
Chelmsford Community Education / Elementary Students

PRIMARY SCHOOL_____PROGRAM(*If CommEd*) _____GRADE_____TEACHER_____

CHILD'S NAME _____DOB_____AGE_____BUS # _____

GENDER_____ HEIGHT_____ WEIGHT_____ lbs.

Are there any custody concerns regarding this child**?** *YES_____ NO_____

In order to comply appropriately, the proper legal documentation must be received by the elementary school office and Chelmsford Community Education if program is used.

CHILD'S ADDRESS _____
Number and Street Town State Zip

WHO DOES THE CHILD LIVE WITH _____

MOTHER/GUARDIAN'S NAME _____HOME PHONE (_____)_____

HOME ADDRESS _____CELLULAR (_____) _____
Number and Street Town State Zip

PLACE OF EMPLOYMENT_____WORK PHONE (_____)_____

FATHER/GUARDIAN'S NAME _____HOME PHONE (_____)_____

HOME ADDRESS _____CELLULAR (_____) _____
Number and Street Town State Zip

PLACE OF EMPLOYMENT_____WORK PHONE (_____)_____

I give permission to communicate with the school nurse via email to meet my child's health and safety needs.
Yes ❑ No ❑ **Parent/Guardian email**_____

PRIORITIZE # FOR QUICK CONTACTING (Call 1st, 2nd etc…)

MOTHER's	(H)	(W)	(C)
FATHER's	(H)	(W)	(C)

*SIBLING INFORMATION – If applicable, please list all siblings, ages, and current schools:

_____

If parent/guardian not available, list the persons you wish to be called and authorized to pick up your child:

Name _____Relationship_____ How child refers to individual_____

Contact numbers_____

Name _____Relationship_____ How child refers to individual_____

Contact numbers_____

Name _____Relationship_____ How child refers to individual_____

Contact numbers_____

Please complete the following if your child goes to a day care/babysitter's part time or every day:

NAME _____ADDRESS _____PHONE (___)_____
Number and Street Town State Zip

DAYS WITH DAY CARE/SITTER Monday Tuesday Wednesday Thursday Friday

Parent/Guardian's Signature:_____**Date**:_____

THIS IS A TWO SIDED FORM

HEALTH INFORMATION

CHILD'S NAME _____ DESIRED HOSPITAL _____

DOCTOR	LOCATION	PHONE ( ) -
EYE DOCTOR	LOCATION	PHONE ( ) -
DENTIST	LOCATION	PHONE ( ) -

*HEALTH INSURANCE NAME_____ DENTAL INSURANCE _____

**If none write "None." The school nurse is available to assist families locating free and or reduced cost insurance.*

If needed, I give permission to the nurse to administer and/or apply the following medications that have been approved by our school physician: acetaminophen(Tylenol), Caladryl, Vaseline, Aquaphor, Ibuprofen (Motrin/Advil), saline eye solutions, Bacitracin, Silvadene Cream, hydrocortisone cream, diphenhydramine(Benadryl), and First Aid Cream? Yes ❑ No ❑

If needed, I give permission to the nurse to share the following information with the appropriate school personnel to meet my child's health, safety, and/or educational needs? Yes ❑ No ❑

I give permission to the nurse to speak with the above listed doctor to meet my child's health and safety needs. Yes ❑ No ❑

Allergies: ☐ My child has **no** allergies ☐ My child **has** the following allergies **Is an EpiPen Prescribed? *Yes ❑ No ❑**

***Foods** child is allergic to:_____ **Environmental**_____

***Medication**_____ ***Bee/Insect**_____ ***Latex**_____ ****Other**_____

****Each school year, an Allergy Medication Plan and Consent Form is required. If no medications are needed at school, then documentation from the doctor indicating such is required.***

Check all conditions that apply:		**Check if no conditions apply: ❑**	
❑ ADD/ADHD	❑ Diabetes	❑ Kidney	❑ Strep throat infections (history of)
❑ Anxiety	❑ Developmental Delays	❑ Lactose Intolerant	❑ Other _____
❑ Asthma	❑ Ear Infections	❑ Migraines	Hospitalizations this year? Yes ❑ No ❑ Reason?_____
❑ Arthritis	❑ Eyeglasses/Contacts	❑ Nosebleeds	
❑ Autism spectrum	❑ Gastric reflux	❑ Reflux (other)	Previous Concussions? Yes ❑ No ❑ Dates_____
❑ Bladder Control	❑ Hearing Loss	❑ Seizures	❑ Emotional Concerns? _____
❑ Constipation	❑ Heart Condition	❑ Scoliosis	_____
❑ Celiac	❑ Heart Murmur		

Is an inhaler and/or nebulizer prescribed for your child? Yes ❑ No ❑ Will it be sent to school? Yes ❑ No ❑

Will it be sent to Community Education ? Yes ❑ No ❑

Medications: Does your child take any daily or as needed medications at home? Yes ❑ No ❑ **if yes, please list*

Medication: _____ Time of Day:_____ Dose:_____ Required during school hours? Yes ❑ No ❑

Medication:_____ Time of Day:_____ Dose:_____ Required during school hours? Yes ❑ No ❑

Medication:_____ Time of Day:_____ Dose:_____ Required during school hours? Yes ❑ No ❑

Medications necessary to be given during the school day and/or the CommEd Childcare *programs, must submit to both offices: 1) written physician's order, 2) written parental permission, and 3) be supplied and delivered by parent in the original labeled container.*

Please list any other medical, emotional, health concerns/issues and/or past medical problem that limits activity at school or can help the School Nurse care for your child: _____

Parent/Guardian's Signature: _____ Date:_____