

**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 \_\_\_\_\_

PARENT 1/GUARDIAN'S NAME \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CELLULAR (\_\_\_\_) \_\_\_\_\_  
Number and Street Town State Zip

PLACE OF EMPLOYMENT \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_

PARENT 2/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 1<sup>st</sup>, 2<sup>nd</sup> etc...)**

PARENT 1	(H)	(W)	(C)
PARENT 2	(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 \_\_\_\_\_

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, Aquaphor, Vaseline, Ibuprofen (Motrin/Advil), saline eye solutions, Bacitracin, Silvadene Cream, hydrocortisone cream, diphenhydramine(Benadryl), and First Aid Cream? <b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>
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? <b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>
I give permission to the nurse to speak with the above listed doctor to meet my child's health and safety needs. <b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>

<b>Allergies:</b> <input type="checkbox"/> My child has <b>no</b> allergies <input type="checkbox"/> My child <b>has</b> the following allergies <b>Is an EpiPen Prescribed? *Yes <input type="checkbox"/> No <input type="checkbox"/></b>
<b>*Foods</b> child is allergic to: _____ <b>Environmental</b> _____
<b>*Medication</b> _____ <b>*Bee/Insect</b> _____ <b>*Latex</b> _____ <b>**Other</b> _____
<b><i>*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.</i></b>

<b>Check all conditions that apply:</b>		<b>Check if no conditions apply: <input type="checkbox"/></b>	
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney	<input type="checkbox"/> Strep throat infections (history of)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Lactose Intolerant	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Migraines	Hospitalizations this year? Yes <input type="checkbox"/> No <input type="checkbox"/> Reason? _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eyeglasses/Contacts	<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Autism spectrum	<input type="checkbox"/> Gastric reflux	<input type="checkbox"/> Reflux (other)	Previous Concussions?    Yes <input type="checkbox"/> No <input type="checkbox"/> Dates _____
<input type="checkbox"/> Bladder Control	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Seizures	<input type="checkbox"/> Emotional Concerns? _____ _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Celiac	<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
Medication: _____	Time of Day: _____	Dose: _____	Required during school hours? Yes <input type="checkbox"/> No <input type="checkbox"/>
Medication: _____	Time of Day: _____	Dose: _____	Required during school hours? Yes <input type="checkbox"/> No <input type="checkbox"/>

*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:** \_\_\_\_\_