CHELMSFORD PUBLIC SCHOOL
Emergency Medical Information

Student's Name: _____ **Date of Birth:** _____

Gender: M ❑ F ❑ **Entering Grade:**_____ **Bus #** _____ **Homeroom/House:** _____

Student Lives With: _____ Student's Address: _____
Siblings/Schools 1st: _____ 2nd: _____
Guardian Name _____ Home# _____ Cell#_____
Employer:_____ Work#_____ Email _____
Additional Guardian Name _____Home# _____ Cell#_____
Employer:_____ Work#_____ Email _____
Which phone # to call First? _____Second?_____
If guardian not available, please list individuals who we can release your child to:

	person(s)	**relationship**	**and phone numbers**
1st	_____	_____	_____, _____, _____
2nd	_____	_____	_____, _____, _____

Allergies: No allergies ❑ Environmental Allergies ❑ Medication Allergies ❑ (List)_____
*Latex ❑ Bee/Insect ❑ *Food ❑ (List) _____ Is Epi pen prescribed? *Yes ❑ No ❑
(***Health Provider's documentation required)*** Has an Epi pen ever been given? Yes ❑ No ❑

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 ❑
❑ Arthritis	❑ Eyeglasses/Contacts	❑ Nosebleeds	Reason?_____
❑ 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 ❑

List all medications your child is taking:
Medication: _____ Time of Day: _____ Dose:_____
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Medication: _____ Time of Day: _____ Dose:_____
Medications necessary to be given during the school day must have a written physician's order, written parental permission, and be supplied and delivered by parent in the original container.

- *If needed*, I give permission for the school nurse to administer and/or apply the following medications approved by our school physician: Bacitracin, Caladryl, First Aid Cream, Hydrocortisone, Hypoallergenic skin lotion, Saline Eye Solution, Silvadene Cream, Sting Kill Swabs, Tums, Ibuprofen (Motrin), diphenhydramine(Benadryl), acetaminophen(Tylenol), Aquaphor or Vaseline. YES ❑ NO ❑
- I give the school nurse permission *when needed*, to share information confidentially with appropriate personnel, to meet my child's health, safety and/or educational needs. YES ❑ NO ❑
- I give the school nurse permission to speak with my listed pediatrician to facilitate care of my child YES ❑ NO ❑

Parent/Guardian signature:_____ Date: _____
Pediatrician:_____Phone: _____ Desired Hospital:_____
**Insurance Provider:_____Dentist: _____Phone:_____

****If your child has no health insurance, *state none*. Massachusetts offers uninsured children health insurance plans for free or at a reduced rate. Please contact the school nurse for information. *All communications are confidential***