Lenox Memorial Middle/High School

Emergency and Health Information Form (Complete **Front and Back Side**/*Please use ink/print clearly)*

School Year_________________ **Grade** _____________

Child's name:____Date of birth__________ Age______

Parent(s)/Guardian(s) Full Name(s)____

Residential Address:____Home Phone _______________________

Town of Residence: ____ Birthplace _________________________

Mailing address:____

____

Child Resides 1.____________________ Relationship____________ Work #____________Cell #________________

With: 2.____________________ Relationship____________ Work #____________Cell #________________

Siblings attending other Lenox Public Schools:

Sibling's full name: Grade:

____________________________________ ______

____________________________________ ______

____________________________________ ______

E-mail address: ____

Persons to Contact for emergency or illness-will assume responsibility/transportation-list in order of preference including parent

1.______________________________ Home phone #_______________ Work # ___________ Cell #______________

2.______________________________ Home phone #_______________ Work #____________Cell #______________

3.______________________________ Home phone #_______________ Work #____________ Cell #______________

Non-custodial parent information (if applicable).

Name____ Relationship to Child____________________________

Residential Address____

Mailing Address____

Home Phone #______________________ Work Phone #_______________________ Cell #_____________________

If there are individuals to whom the school SHOULD NOT DISMISS YOUR CHILD TO because there is a legal, updated court document on file with the school, PLEASE LIST BELOW:

Name(s)____

COMPLETE STUDENT HEALTH INFORMATION ON BACK SIDE →

Current Health Information (This Page to School Nurse's Office only)

Physician: ____ Phone #___________________

Additional Physicians child sees: ____

Dentist: ____ Phone #___________________

Health Insurance: YES _____ Private __________ Public___________ (Mass Health, CMSP)

NO _____

Need confidential assistance obtaining health insurance for your child? YES_____ NO_____

Child's Health Problems (Heart Condition, Diabetes, Asthma, Seizure Disorder, Other):

____

____

- [ ] Hearing Problems Left ear ____ Right ear ____ Hearing Aids _____
- [ ] Vision Problems Wears Eyeglasses _____ Wears Contact Lenses ______

Child's Allergies (food, insects, medication, environmental) **& describe child's reactions**:

____

____

Names of any Medications taken regularly:

____

Any additional health information the school health office should be aware of:

____

I give permission for the school nurse to provide information relevant to my child's health condition to appropriate school personnel when necessary to meet my child's health and safety needs, and to exchange my child's information with medical authorities for the purpose of referral, diagnosis and treatment. I also give permission for ambulance transport to the hospital in the event that emergency treatment is determined necessary.

Parent/Guardian Signature____ Date _________________

Grade 6 – 12 Students Only

Consent for Over The Counter (OTC) medication to be Given in School

Name of Student____

I give permission to have the school nurse or school personnel designated by the school nurse give the following medications with dosage and times as per school physician protocols: **(Circle medications to be given)**

Advil (Ibuprofen) Tylenol (Acetaminophen) Benadryl (Hives/Allergies) Antacid/Peppermint Cough Drops Bacitracin ointment Benadryl lotion Anti-itch gel

I understand that **any medication** which needs to be administered at school, **other than the list above** will need to be **brought in by a parent** in the **original container** and requires a **physician order** to be dispensed by the school nurse or school personnel designated by the school nurse. Forms are available in the school health office.

Parent/Guardian Signature____ Date__________________