Westborough Public Schools

STUDENT HEALTH INFORMATION

Grades 4 - 6

Please complete accurately as this will accompany your child to the hospital if emergency treatment is needed, and return as soon as possible.*

Student's name _____ Date of Birth _____Sex___ Grade ____

Address _____ Home Phone _____

Father's Name _____ Mother's Name _____

Employer _____ Employer _____

Work Phone _____ Work Phone _____

Cell Phone _____ Cell Phone _____

Child lives with _____ Language spoken at home _____

Siblings/ages _____

Emergency Contacts (Local adults who will care for your child if you cannot be reached)

Name _____ Daytime phone _____

Name _____ Daytime phone _____

Health Care Providers

Doctor/NP/PA _____ Phone _____

Dentist _____ Phone _____

Health Insurance Co. _____ Policy # _____

If you do not have health insurance, please contact the school nurse for information about Massachusetts programs.

Health Problems (such as asthma, diabetes, heart conditions, seizures, migraines, - please attach additional pages if needed)

_____

Allergies: ❒ Food ❒ Insects ❒ Medication ❒ Other: _____

Please specify source/treatment: _____

Limitations in physical activity (PE, recess, team sports) _____

Medication that your child takes (dose/time) _____

If your child requires medicine or any special treatment while at school, please contact the school nurse. A signed order from a licensed prescriber and parental permission are required for ANY medicine or treatment given in school.

- I give permission for the nurse to provide minor first aid treatment which may include the application of antibiotic ointment or skin care products such as a mild cleanser, hand lotion, or lotion with caladryl, aloe, or lidocaine.
- I give permission for the nurse to share relevant information with appropriate school personnel to meet the health and safety needs of my child.
- In case of accident or serious illness, I request that the school nurse contact me. If unable to reach me or one of my designees, I authorize the school to contact my child's medical provider. If needed, the school will call 911 and send my child with an adult from school to the hospital for emergency treatment. The school has no liability for medical costs.

Parent/Guardian signature _____ Date _____