

**Westborough Public Schools**  
**STUDENT HEALTH INFORMATION**  
**Grades 7 - 12**

*Vision, hearing, & BMI (height & weight) screenings are done in grades 7 & 10. Postural Screenings are done in grade 7, 8, & 9. Please notify the school nurse within the first 2 weeks of school if you do not want your child to participate in the BMI screening.*

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Is address/ phone changed in past year  Yes  No  
Father's Name \_\_\_\_\_ Can Dismiss student:  Yes  No  
Mother's Name \_\_\_\_\_ Can dismiss student:  Yes  No  
Father's Employer \_\_\_\_\_ Mother's Employer \_\_\_\_\_  
Father's Work Phone \_\_\_\_\_ Mother's Work Phone \_\_\_\_\_  
Father's Cell Phone \_\_\_\_\_ Mother's 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 \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**HEALTH CARE PROVIDERS**

Doctor/NP/PA \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Health insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

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

**HEALTH PROBLEMS** (such as asthma, heart conditions, seizures, migraines or allergies - please attach additional pages if necessary)

\_\_\_\_\_

**LIMITATIONS ON PHYSICAL ACTIVITY**

\_\_\_\_\_

*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 treatment or medicines given at school (except as noted on reverse).*

If the nurse is unable to reach me or one of my designees, I authorize the school to contact my child's healthcare providers. If indicated, the school will call 911 and send my child to the hospital for emergency treatment. The school has no liability for medical costs.

May the school nurse share the above information with appropriate school personnel?  Yes  No

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM\***

**ALLERGIES**

Food  Insects  Medication  Environmental  Other: \_\_\_\_\_

Please specify source/treatment \_\_\_\_\_

**MEDICATIONS TAKEN BY YOUR CHILD** (including those taken at home)

\_\_\_\_\_  
\_\_\_\_\_

**PARENTAL CONSENT for OVER-THE-COUNTER MEDICATIONS (during school hours)**

*I give permission for the school nurse to provide and administer the following over-the-counter medications to my child, as needed, based on nursing assessment:*

**Acetaminophen (Tylenol):** For mild to moderate discomfort of muscles, menstrual cramps, toothache, headache, mild fever. (Note: Any student with a temperature greater than 100.6 ° F must be dismissed to a parent or emergency contact.)

Yes  No

**Ibuprofen (Advil, Motrin, Nuprin):** For mild to moderate discomfort of muscles, menstrual cramps, toothache, headache, mild fever. (Note: Any student with a temperature greater than 100.6 ° F must be dismissed to a parent or emergency contact.)

Yes  No

**Tums (Calcium carbonate):** For indigestion, stomach upset.

Yes  No

**Topical application of soap or a mild cleanser, antibiotic ointment, or skin care products including hand lotion, caladryl, or lotion with aloe or lidocaine:** For minor first aid treatment.

Yes  No

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*Please refer to the Westborough Schools web site for more information about health services provided at your child’s school. You will also find information related to adolescent health issues.\**