

Ware Public Schools—Health Services

School Year 2018-2019

Student Information

Name _____ Date of Birth _____ Male / Female
Last First (circle one)

Street Address _____ Town _____

Mailing Address (if diff) _____ Home phone (____) _____

Preferred Primary Contact for All School Health Matters

(MUST be parent/guardian with actual physical custody)

Name _____ Daytime location _____

Relation _____ phone # (____) _____

Alternate / Cell # (____) _____

Secondary Contact for Urgent School Health Matters

(Responsible ADULT able to bring student home or to a hospital or physician's office for medical attention)

Name _____ Daytime location _____

Relation _____ phone # (____) _____

Alternate / Cell # (____) _____

I understand school personnel will contact me in case my child is seriously ill or injured. In an emergency, school personnel may arrange for my child to be transported to a hospital for medical care not available at the school. Regardless of age over or under 18, my child will not be dismissed alone (or with an emergency contact) without my express specific consent for any non-emergent reasons.

Parent/Guardian signature _____ Date _____

Please contact the School Nurse if there are any changes to the student's information during the course of the school year.

SIGN BELOW FOR THIS STUDENT TO RECEIVE OVER-THE-COUNTER (OTC) MEDICATIONS AT SCHOOL.

I give permission for the School Nurse to administer the following medications as necessary (call Nurse for specific concerns):

FOR PAIN/DISCOMFORT Acetaminophen (i.e. Tylenol) Ibuprofen (i.e. Advil/Motrin)
(These medications may also be given for fever over 101 F if dismissal will be delayed and student is very uncomfortable.)

FOR ALLERGIES Diphenhydramine (i.e. Benadryl) **FOR SORE THROAT/COUGH** Throat lozenges

FOR WOUNDS Antiseptic Liquid (i.e. Bactine) Antibiotic Ointment

FOR SKIN Cooling Burn Cream or Gel Calamine Lotion Caladryl Lotion

FOR UPSET STOMACH Antacid/Anti-Gas (i.e. TUMS/Mylanta) **FOR GUM/TOOTH PAIN** Anbesol

I understand the School Nurse may decline to administer an OTC medication if, in his / her judgment, other relief measures should be attempted first or if further medical evaluation may be needed for the symptoms. I also understand, by MA General Laws, oral OTC medications CANNOT be given by ANY school personnel except a School Nurse regardless of parent request or consent; this includes during field trips, after-school programs, or other school-sponsored events.

Parent/Guardian signature _____ Date _____

COMPLETE HEALTH INFORMATION ON BACK OF FORM

Ware Public Schools—Health Services

Health Information

Name _____ **Gr.** _____ **Teacher** (homeroom) _____

Date of Last Physical Exam _____
 Problems found _____

Physician's Name _____
 Town _____ Phone (____) _____

Date of Last Dental Exam _____
 Problems found _____

Dentist's Name _____
 Town _____ Phone (____) _____

Date of Last Eye Exam _____
 (NOT school vision screening)

Glasses / Contacts: FULL TIME / DISTANCE / READING
 (circle how glasses used)

Health Insurance _____ If student does not have ANY Health Insurance coverage, write: "NONE"
 (NAME of insurance only)

Check ONE Column to RIGHT and COMMENT, if applicable

Health History (describe & note any medications currently used for this problem)	Never	Past (no concerns in 2+ years)	Recent (new concern in past year)	Ongoing (persistent over 1 year)
Allergic reactions				
Asthma				
Chickenpox / Mononucleosis				
Diabetes				
Ear Infections				
Fainting / Seizures				
Fractures / Dislocations / Sprains				
Frequent headaches				
Heart Problems / Murmurs				
Kidney or urination problems				
Major Head / Neck / Back injury				
Psych / Emotional / Behavioral Concern				
Respiratory infections				
Seasonal allergies				
Skin problems / rashes				
Stomach / bowel problems				
Throat problems				
Other (specify)				
Other (specify)				

Seen by MD or in ER in past 3 months FOR URGENT OR EMERGENCY CARE? (reason / recommendations) _____

Hospitalizations / Operations (explain) _____

Seen by a specialist? (specify reason and name of doctor) _____

What prescription medication(s) does he / she take on a regular basis? (reason ?) _____

(If any medication must be taken during school hours, contact the School Nurse to arrange for a physician's order.)

Does your child have any physical limitations that require school program modification or restrictions? _____

Additional Comments _____

The School Nurse may communicate with other individuals (teachers, administration, physician, medical personnel) working with my child regarding his/her health. Any information will be given ONLY for the purpose of protecting or promoting health or providing appropriate educational services. The School Nurse may receive from my child's medical care provider any medical information necessary to provide school health services for my child.

Parent/Guardian signature _____ **Date** _____

TURN PAGE OVER AND COMPLETE STUDENT / CONTACT INFORMATION