AMSACS HEALTH OFFICE EMERGENCY INFORMATION 2023-24

Student's Name: _____ Grade: 6 7 8 9 10 11 12
Last First Full Middle Name (do not use initials)

Address: _____ Town/City _____ Zip Code _____

Home Phone: _____ Home Email Address: _____

Date of Birth: _____ City/State of Birth: _____ Mothers Maiden Name: _____

Gender: M F Nonbinary Primary Language: _____Does your child have health insurance? ☐ No* ☐ Yes

Policy Name: _____ Policy #: _____

Student cell phone: _____ Student email: _____

*If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable/free health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

Name & grade of siblings in school building: _____

In case of medical emergency, the school will make attempts to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if deemed necessary. Please complete physician information

Student's Physician: _____ Phone: _____
Date of last appointment: _____ List Immunizations given in last year: _____

Student's Dentist: _____ _____ Phone: _____
Date of last appointment _____ Does your child have dental insurance? ☐ Yes ☐ No

FAMILY DAYTIME CONTACT INFORMATION

Primary Contact #1

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Place of Employment: _____

Work Phone: _____ext.: _____

Email Address: _____

Primary Contact #2

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Place of Employment: _____

Work Phone: _____ext.: _____

Email Address: _____

Other Custodial/Step Parent/Guardian:

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Place of Employment: _____

Work Phone: _____ext.: _____

Email Address: _____

Please indicate if your child may be released to non-custodial parent in case of illness and/or an emergency
☐ yes ☐no

Other Contacts

Please indicate names of friends/relative/neighbor that will assume responsibility and provide transportation for your child in case of illness/injury/emergency/school evacuation when parent(s)/guardians cannot be reached. **Your child cannot be released to anyone other than those you list here.**

1. Name: _____
Relationship: _____
Daytime Phone: _____

2. Name: _____
Relationship: _____
Daytime Phone: _____

TURN OVER AND COMPLETE OTHER SIDE PLEASE

Student's Name: _____ Grade: 6 7 8 9 10 11 12

☐ Bus ☐ Parent Pick-Up ☐ Extended Day Program ☐ After School Program
☐ Other (Specify) _____

Please check all that apply ☐ Anxiety ☐ Asthma ☐ Celiac Disease
☐ Heart Condition ☐ Diabetes ☐ Autism ☐ Seizure Disorder
☐ Migraines ☐ Depression ☐ ADD/ADHD ☐ OCD ☐ Lactose Intolerant
☐ Other (Specify) _____

☐ Allergies/Intolerance: To what? (food, insects, medication, environment) Specify _____

_____

Does your child have an Epinephrine Auto-injector? ☐ No ☐ Yes Specify _____

Does your child have a Metered Dose Inhaler? ☐ No ☐ Yes Specify _____

Please specify any medications or treatments your child will/may need during school hours: _____

_____

Please List all Medications your child is taking at home: _____

Note: Students are **not allowed by law** to carry any medications, over-the-counter or prescriptions. If your child has a medical condition or is on medications, please fill out the required medication forms and contact the school nurse if you have not already done so.

Please Specify Problems with:

☐ Vision ☐ Right ☐ Left ☐ Eyeglasses ☐ Contacts ☐ Preferential Seating
☐ Hearing ☐ Right ☐ Left ☐ Hearing Aid ☐ Tubes ☐ Preferential Seating
☐ Dental ☐ Braces ☐ Other _____
☐ Speech _____
☐ Bone or Joint _____ ☐ Muscular/Skeletal _____
☐ Gastro/Intestinal _____ ☐ Kidney/Urinary __ _____
☐ Other _____

Does your child have any physical limitations? ☐ No ☐ Yes _____

Does your child need any special equipment? (walker, wheelchair, etc.) ☐ No ☐ Yes _____

Has Your Child been hospitalized during the past year? ☐ No ☐ Yes _____

Please send in updated physical exams and immunizations directly to the school nurse as they occur. State law requires health records to be complete to attend school. This form needs to be filled out each year.

- I give the school nurse permission to share this information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. ☐ Yes ☐ No
- I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment. ☐ Yes ☐ No
- In case of an accident or serious injury and I cannot be reached at the numbers above, I hereby authorize the school to arrange transportation to the nearest hospital emergency room to be treated by the physician on duty. ☐ Yes ☐ No

Signature (custodial parent/guardian) _____ Date: _____

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