EMERGENCY HEALTH INFORMATION SHEET

Please complete for Nurse's Office. Inform nurse of any changes during the school year.

Bus #: _____Grade: _____ Teacher: _____

Student Name: _____Date of Birth: _____

Student lives with: Both Parents ☐ Mother ☐ Father☐ Guardian☐

Parent/Guardian #1: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____
Place of Employment Hours

Parent/Guardian #2: _____ Cell Phone: _____

Address (if different): _____ Home Phone: _____

_____ Work Phone: _____
Place of Employment Hours

Siblings: _____
Name/DOB Name/DOB

_____
Name/DOB Name/DOB

Students who are ill need to be isolated and picked up within 45 minutes. In the event that a parent cannot be reached, please list two individuals who are available during the day to pick up your child. Please note that identifying an emergency contact for pickup may have implications for that person should the ill student test positive for COVID-19.

Name:_____ Relationship: _____

Address: _____Tel: _____Cell:_____

Name: _____ Relationship: _____

Address: _____Tel: _____Cell:_____

The following over the counter medications, or the generic equivalent, are ordered by the school physician for student use: Tylenol, Advil/Motrin, Benadryl, Tums, Caladryl, Hydrocortisone ointment, antibiotic ointment and hand sanitizer.
My child may have any of the above medications if needed.

YES☐ NO☐ If no, please list any of the above medications that you **do not** want your child to receive._____

Health information may be shared with school/professional personnel on a need-to-know basis.

YES☐ NO☐

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Signature of parent or guardian: _____ Date: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health Insurance: _____
Company **ID Number**

ANNUAL HEALTH HISTORY
(To be completed by parent)

Dear Parent or Guardian:
The following information is requested yearly so that the school and parent can work together to meet the physical, intellectual and emotional needs of the child. **A physical exam is required of all students newly entering Dover and Sherborn Public Schools as well as upon entering Kindergarten, Grades 3, 7, and 10**. Please ask your health care provider to supply you with a completed form, signed by a doctor or nurse practitioner, to give to the school nurse. Blank exam forms are available from the school nurse if needed.

Student Name: _____ Grade: _____

HEALTH HISTORY

**Please indicate if your child has issues in any of the following areas:	YES	NO
1. Allergies or reactions: (example: food, medication, environmental, other) **List below***		
2. Asthma/ breathing difficulties		
3. Eczema or frequent skin rashes		
4. Neurological (ADHD/Seizures/Autism Spectrum)		
5. Cardiac		
6. Diabetes		
7. Frequent colds, sore throats, earaches (4 or more per year)		
8. Urinary, bowel or stomach		
9. Dietary restrictions		
10. Speech		
11. Menstrual		
12. Dental Date of last examination		
13. Vision Impairments (colorblind,glasses/contacts)		
14. Hearing Impairments		
15. Accidents/hospitalizations (including head injuries/concussions)		
16. Headaches (frequent and/or severe)		
17. Current orthopedic concerns including Scoliosis or back/spinal issues		
18. Psychosocial issue (anxiety/depression/eating disorder, etc.)		
19. Other chronic or significant conditions:		
*Please explain any problem areas identified above: List any special equipment used in school:		

Current Medications/Supplements:

	Medication Name	Dosage	Time(s) given	Reason for medication
1				
2				
3				
4				

Parent/Guardian Signature: _____ Date: _____

Please return promptly. May be place in a sealed envelope addressed to the nurse.