|  |  |
| --- | --- |
| Last Name:      | First Name: |
| Middle Name:      | Home Phone:      |
| Gender:      | Street:      |
| Is Current SPS Student?:      | Birth date:      |
| Guardianship: |  |
|  |  |
| Mother’s Name: | Mother’s Phone:      |
| Mother’s Cell:      | Mother’s Work Phone:      |
| Mother’s email:      |
|  |  |
| Father’s Name:      | Father’s Phone:      |
| Father’s Cell:      | Father’s Work Phone:      |
| Father’s email:      |
|  |  |
| Guardian Name:     (if other than parent) | Guardian Phone:      |
| Guardian Cell:      | Guardian Cell Phone:      |

Contacts 1 and 2 are, in most cases, friends or relatives who are willing to take responsibility for the student in case of illness or emergency.

|  |  |
| --- | --- |
| Contact 1:      | Relationship:      |
| Contact 1 Phone:      | Contact 1 Cell:       | Contact 1 Work:      |
|  |  |
| Contact 2:      | Relationship:      |
| Contact 2 Phone:      | Contact 2 Cell:      | Contact 2Work:      |
|  |  |  |
| Physician’s Name:      | Physician’s Phone:      |

Please contact the school nurse if you need assistance obtaining medical insurance.

1. If there is a medical condition that the school should be aware of, please contact the nurse.
2. I give permission to the school nurse to share information relevant to my child’s health condition with appropriate school when needed to meet my child’s health and safety needs.
3. I give permission to the school nurse to treat and arrange emergency transport for my child as needed.
4. The federal government has ruled schools can be reimbursed through Medicaid for special education services. I give permission to the students Mass Health Card # to bill for the special education services rendered.

Signature of Parent/Guardian:

|  |  |
| --- | --- |
| Date      | Grade:      |
| Student Name:      | D.O.B:      |
| Parent/Guardian:      | Phone:      |
| Address:      |
| Primary Physician’s Name:      |
| List and fractures, sprains, | Date or Age:      |
| or bone dislocations:      |
| Reason:      |

Has you child ever had any of the following? Please check the box if yes.

Asthma and/or Allergies [ ]  Mononucleosis [ ]

Fainting and/or Convulsions [ ]  Hepatitis [ ]

Rheumatic Fever [ ]  Bronchitis [ ]

Kidney Disease/Injury [ ]  Head Injury [ ]

Heat Stroke/Heat Exhaustion [ ]  Concussion [ ]

Diabetes [ ]  Seizure [ ]

Menstrual Disorders [ ]  Serious Dental Problems [ ]

Blood Disorders [ ]  Tumors [ ]

If any of the above are checked, please explain:

Are the any other serious illnesses or injuries?

Does your child take any medicaions now (prescription and/or “over the counter”)?

If Yes, name, dose and frequency:

[ ]  I give permission to the school nurse to administer the following medication/treatments per label directions:

Acetaminophen (Tylenol), Iburprofen, Bacitracin, Hydrocortisone Cream 1%, and Calmine/Caladryl

[ ] School Nurse may administer all of the above medications/treatments except for:

\*\*\*If your child requires medication during the summer school day, please have your physician complete the Shrewsbury Public Schools “Medication Order” form, also avalialable on the website.

|  |  |
| --- | --- |
| Parent Signature      | Date:      |