EAST LONGMEADOW PUBLIC SCHOOLS
Student Health and Emergency Information

Grade: ___________
Room: -----------------

Please complete the following form (BOTH sides) & return to the School Nurse by September 18, 2020

Student's Name: M/F DOB:

(Last) *(First)* *(Middle)*

Address: Language spoken at home: ________________

Both parents reside at above address ( )yes ( )no

Parent/Guardian # 1: _________________________ Home # _______________Work #_______________ Cell #________________

Parent/Guardian # 2: _________________________ Home # _______________Work # _______________ Cell #________________

Name of others who may provide assistance/transportation to your child during the school day, if you are not available.

Other contact #1: ___________________________ Relationship: ____________________ Phone # ________________________

Other contact #2____________________________ Relationship: ____________________ Phone # ________________________

Name/grade of sisters/brothers in school district: ____

Transportation: **To school**: ☐ Bus ☐ driven/drives ☐ walks **From school**: ☐ Bus ☐ driven/drives ☐ walks

Are you a **military** connected family? ☐ Yes ☐ No For more info: 1-800-342-9647 or www.militaryonesource.mil

For **drug/alcohol** information: 1-**800-327-5050** or Central Intake and Care Coordination **Toll free #1- 866-705-2807 mass.gov/StateWithoutStigMA**

Do you have **health insurance**? ☐ Yes ☐ No Name of **health insurance provider**: __________________________

In case of an emergency, 911 will be called and the school will attempt to contact parent/guardian.
Your child will be transported by ambulance to an emergency care facility, if necessary.
Indicate **hospital preference**: ____

Physician name: Phone # Last visit date:

Dentist name: Phone # Last visit date:

Please list medications **required during school hours**: ____

____

Other **medications** your child takes **at home**: ____

Please check all physician diagnosed conditions that apply to your child

☐ ADD/ADHD ☐ Anxiety ☐ Asthma ☐ Autism ☐ Depression ☐ Diabetes ☐ Heart condition

☐ Migraines ☐ Scoliosis ☐ Seizure Disorder ☐ Other ____

☐ Non-life-threatening allergies, (i.e. food, insects, medication, environment, latex.) (Specify):

____

☐ Life-threatening allergies: (Specify) __________________________Allergist_____________ Last visit_____________

☐ A significant illness or injury in the past 12 months (Specify):____

☐ Hearing problems (Specify): ☐ Left ear ☐ Right ear ☐ Hearing aids

☐ Vision problems (Specify): ☐ Wears eyeglasses ☐ Contact lenses

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I also give permission to exchange information with my child's health care provider, for the purpose of referral, diagnosis, treatment, and well-being.

Signature ____ Date ___________________________

****** PLEASE COMPLETE BOTH SIDES ******

East Longmeadow High School
Over-the-Counter Medication Information

Student's name ____

I give permission for the school Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. I have crossed out and initialed any products that I do not wish my child to receive. All other medications require a written doctor's order and a written parental permission. Please contact the school Nurse for additional information and the proper forms.

Acetaminophen (Tylenol)	Tablets or liquid --- (grades 3 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. **School Nurse may limit frequent administration of Tylenol.*
Bacitracin ointment	As needed for cuts, scrapes, etc.
Benadryl	Tablet or liquid --- (children/adult 6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.
Ibuprofen	Tablets- (children/adult 12 years and older) As needed for menstrual cramps, minor discomfort, headache, musculoskeletal pain, dental pain, etc.
Medique lozenges	As needed for minor throat dryness, irritation, etc.
Moisturizing eye drops	As needed to flush the eyes or moisturize dry eyes.
Tums (antacid)	As needed for minor gastric distress or indigestion.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent's signature ____ **Date** ______________

****** PLEASE COMPLETE BOTH SIDES ******

Birchland Park Middle School
Over-the-Counter Medication Information

Student's name ____

I give permission for the school Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. I have crossed out and initialed any products that I do not wish my child to receive. All other medications require a written doctor's order and a written parental permission. Please contact the school Nurse for additional information and the proper forms.

Acetaminophen (Tylenol)	Tablets or liquid --- (grades 3 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. **School Nurse may limit frequent administration of Tylenol.*
Bacitracin Ointment	As needed for cuts, scrapes, etc.
Benadryl	Tablet or liquid --- (children/adult 6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.
Ibuprofen	Tablets---(children/adult 12 years and older) As needed for menstrual cramps, minor discomfort, headache, Musculoskeletal pain, dental pain, etc. *School nurse may limit frequent administration of Ibuprofen.
Medique lozenges	As needed for minor throat dryness, irritation, etc.
Moisturizing eye drops	As needed to flush the eyes or moisturize dry eyes.
Tums (antacid)	As needed for minor gastric distress or indigestion.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent's signature ____ **Date** ______________

****** PLEASE COMPLETE BOTH SIDES ******

Mountain View School
Over-the-Counter Medication Information

Student's name ____

I give permission for the school Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. I have crossed out and initialed any products that I do not wish my child to receive. All other medications require a written doctor's order and a written parental permission. Please contact the school Nurse for additional information and the proper forms.

Acetaminophen (Tylenol)	Tablets or liquid --- (grades 3 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. *School Nurse may limit frequent administration of Tylenol.*
Bacitracin ointment	As needed for cuts, scrapes, etc.
Benadryl	Tablet or liquid --- (children/adult 6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.
Medique lozenges	As needed for minor throat dryness, irritation, etc.
Tums (antacid)	As needed for minor gastric distress or indigestion.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent's signature ____ **Date** ______________

****** PLEASE COMPLETE BOTH SIDES ******

Mapleshade School
Over-the-Counter Medication Information

Student's name ____

I give permission for the school Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. I have crossed out and initialed any products that I do not wish my child to receive. All other medications require a written doctor's order and a written parental permission. Please contact the school Nurse for additional information and the proper forms.

Acetaminophen (Tylenol)	Tablets or liquid --- (grades 3 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. *School Nurse may limit frequent administration of Tylenol.*
Bacitracin ointment	As needed for cuts, scrapes, etc.
Benadryl	Tablet or liquid --- (children/adult 6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.
Medique lozenges	As needed for minor throat dryness, irritation, etc.
Tums (antacid)	As needed for minor gastric distress or indigestion.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent's signature ____ **Date** _____________

****** PLEASE COMPLETE BOTH SIDES ******

Meadow Brook School
Over-the-Counter Medication Information

Student's name ____

I give permission for the school Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. I have crossed out any products that I do not wish my child to receive.

All other medications require a written doctor's order and a written parental permission. Please contact the school Nurse for additional information and the proper forms.

Acetaminophen (Tylenol) (Children's liquid)	For oral temperature above 102. See weight chart for dosages.
Bacitracin ointment	As needed for cuts, scrapes, etc.
Benadryl	Tablet or liquid (children/adult 6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent's signature ________________________________ **Date** ______________

****** PLEASE COMPLETE BOTH SIDES ******