GLOUCESTER PUBLIC SCHOOLS
Gloucester, MA 01930

Student Health Form
2010-2011 School Year

Child's Name: _____ Date of Birth: _____ /____/_____
Last Name First Name Middle Name MONTH DAY YEAR

Street Address: _____City: _____ State: _____ Zip:_____

Does your child have Health Insurance? Yes_____ No_____

Does your child have Dental Insurance? Yes_____ No_____

Health Insurance Carrier _____ Dental Insurance Carrier_____

Policy #_____ Policy # _____

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

In case of emergency, the school will attempt to contact parent/guardian before calling the student's primary care provider (physician). In the event that we are unable to contact you, your child will be transported by ambulance to Addison Gilbert Hospital Emergency Department accompanied by a staff member.

Physician Name _____ ____ Phone _____

Dentist Name _____ Phone _____

Please list all medication your child takes:
_____

Please check all that apply to your child: Heart Condition ____ Diabetes ____ Asthma _____ ADD/ADHD ____

Seizure Disorder____ Migraines____ Depression____ Other (specify) _____

Allergies (food, medication, environmental, insect) specify_____

Hearing Problems (specify) _____ Left Ear _____ Right Ear_____ Hearing Aides_____

Vision Problems (specify) _____ Eyeglasses ____ Contacts____ Preferential Seating____

I give the school nurse permission to administer the following over the counter medications accordance with the established protocols. Tylenol will only be administered to children grades 4 and above. Advil will only be administered to children age 12 and over. Tums will be administered to high school students only.

Advil _____ Anbesol____ Benadryl_____ Insect Sting Relief_____ Tylenol_____ Tums_____

The following medication must be provided by the parent to be administered by the school nurse:

Robitussin _____ Cepacol/throat lozenge/cough drop _____

I give permission to the school nurse to share information relevant to my Child's health conditions with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care provider for the purpose of referral, diagnosis and treatment. I give Addison Gilbert Hospital permission to administer emergency care. Any such action will be taken in the best interest of my child and will be reported to me as soon as possible.

Parent/Guardian Signature _____Date _____