Emergency Information Card

PRE/ESTEN/JEFF/MP/RMS/RHS/OOD

Student Name ______________________________ Grade ____ Homeroom ______________
Last First MI

ddress ______________________ Home Tel. ______________ Birth Date ______________

Please list best phone number for automated message: ______________________________

Where can parents/guardian be reached when not at home?

Name ______________ Work Tel ______________ Cell Tel ______________ Email ______________

Name ______________ Work Tel ______________ Cell Tel ______________ Email ______________

Signature of Parent or Guardian ______________________________ Date ______________

Is there anyone your child CANNOT be dismissed to? _____yes _____ no If so, list name ______________

List two nearby neighbors or relatives who will assume temporary care of your child if you cannot be reached

1. Name ______________________________ Tel. ______________
2. Name ______________________________ Tel. ______________

Local Physician's Name ______________________________ Tel. ______________

Local Dentist's Name ______________________________ Tel. ______________

In case of accident or serious illness, I request the school to contact me and, if needed, transport to ______________ Hospital

Allergies: ______________________ Medical Conditions: ______________________

May the following over the counter medications be given? Tylenol? Yes ____ No ____ Advil? Yes ____ No ____

Preschool/Elementary Only - May sunscreen be applied, if needed, for outdoor events? Yes ____ No ____

RHS/RMS Only – Sudafed? Yes ____ No ____ Antacids? Yes____ No ____ Robitussin? Yes ____ No ____

ıedical Insurance Co. ______________________ Dental Insurance Co. ______________________

Release of information regarding Medicaid

I certify that I have read and understand the enclosed letter pertaining to One-time Consent to allow School District Access to MassHealth (Medicaid) Benefits. I give my consent to the school district to access these benefits if my child is an eligible student. I further understand that this will be of no cost to me, will not impact the provisions of IEP services to my child or benefits available to him/her under MassHealth, and that I may revoke my consent at any time.

Parent/Guardian Signature: ______________________________ Date: ______________

In order that we may better manage your child's Health Care needs (especially in an emergency), please fill out the following information if it applies to your child.

What, if any, PRESCRIPTION medication does your child take at home on a regular basis? Daily and/or as needed.

Medication	Dosage	Time

'ay this information be shared with classroom teacher on a "need to know" basis? ☐ Yes ☐ No