Nashoba Valley Technical High School **Grade_____**
School Year 2023-2024 **ID#_____**
Student Emergency and Health Form
(please complete and return to the school nurse)

Student Name _____ Date of Birth _____ Birthplace _____
Last First
Address _____Town _____ Zip _____ Circle sex: Male/Female

Parent/Guardian 1 _____ Street Address _____Town/Zip _____

Email: _____ Phone 1: _____ Phone 2: _____

Parent/Guardian 2 _____ Street Address _____Town/Zip _____

Email: _____ Phone 1: _____ Phone 2: _____

Siblings

Name					
Age					
School					

With whom does the student reside? _____ List address & phone _____
Primary language at home: _____ if different

Emergency Contacts/Release: Local persons to be notified in case of emergency or illness, when you are unable to be reached. ***Your child will only be released to the care of those listed below.***

Name	Relationship	Home Tel.	Work	Cell

Health History: Life Threatening Allergies

Indicate if your child has a *physician verified* allergy to any of the following. *If yes, please provide official documentation by your child's physician to the school nurse at the beginning of the school year. All medication requires a written physician's order.

Bee Stings _____ Peanuts _____ Nuts _____Food (please specify) _____Other_____ Medications _____

Describe your child's allergic reaction. _____ Emergency Care Plan _____

Is Epi Pen required? Yes___ No___ Is Benadryl required? Yes___ No___

Has Epi Pen ever been used? Yes___ No___ Has Benadryl ever been used? Yes___ No___

Does your child carry his/her own Epi Pen? Yes___ No___ Asthma inhaler Yes___ No___

Indicate treatment for allergic reaction at school. _____

Illness/Chronic Conditions:

Please list any illnesses your child is being treated for:_____

_____

Please complete reverse side of form.

Does your child have any dietary or physical limitations?_____
_____

(Please note that a note from your child's physician is required to excuse a child from any school activity, including physical education.)

Please add any information regarding your child's physical or emotional status which may help us make their education more productive:_____
_____

Medications: Please list prescription and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Note: Prescription and over-the-counter medications which your child must take at school require an MD/NP order – please refer to the Medication Policy for details.

Vision Eyeglasses _____ Contact Lenses _____ Date of last eye exam _____

Dental Dental Insurance Yes___ No___ Do benefits include? Fluoride ____ Cleanings _____ Sealants ___
Does your child visit the dentist every six months? Yes___ No___ Date of last exam _____

Health Care Provider Information:

Physician: _____
Name Street Address Town Zip Telephone

Dentist: _____
Name Street Address Town Zip Telephone

Health Insurance Name of company _____ Mass Health _____ No Insurance _____

Subscriber _____ Policy Number _____ Hospital Preference_____

MEDICATION ADMINISTRATION: All prescription and Over the Counter (OTC) medications not listed below require a written physician's order. Per protocol, administration of the OTC medications listed below would not require a physician's order. Communication with the school nurse IS required to arrange for medication administration.

My child has permission to receive the following OTC medications or generic substitutions (please check): Acetaminophen (Tylenol) __ Ibuprofen (Advil, Motrin) __ Antacid (Tums) __ Benadryl __.

Please note: The above OTC medications may be given only once during the school day and no more than 5 times in a two week period. Medications required more frequently must be ordered by an MD/NP. Also, the school nurse may use first aid treatments, including topical ones (i.e. Bacitracin, hydrocortisone, calamine) to treat allergic rashes, insect bites, toothaches, minor wound infections and minor burns unless otherwise indicated by parent/guardian.

Confidential Information I grant permission to the school nurse to share health information about my child, on a need to know basis, with his/her teachers and coaches. Yes _____ No _____

Medical Release I understand that the Nashoba Technical High School has a responsibility to my son/daughter to use responsible and prudent judgment in maintaining his/her health while engaged in the school's programs. With this in mind and in my absence: In the event of an injury or illness, I hereby give my permission for my son/daughter to receive medication and/or any other appropriate treatment (including emergency surgery) by an area doctor, hospital or other appropriate medical facility.

Parent/Guardian Signature: _____ Date: _____

Health Care Provider Release I grant the school nurse permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time. Yes___ No___

Parent/Guardian Signature: _____ Date: _____

Please complete reverse side of form.