STUDENT HEALTH AND EMERGENCY INFORMATION FORM
THE HARVARD PUBLIC SCHOOLS

Please complete the following information and return to the School Nurse

Student's Name _____ Grade _____
Last First Middle
Home Phone ( )_____
►Mother/Guardian/Other _____
Employer _____ Phone number ( )_____
Cell phone ( ) _____ Pager ( ) _____
►Father/Guardian/Other _____
Employer _____ Phone number ( ) _____
Cell phone ( ) _____ Pager ( ) _____
►Physician Name _____ Phone ( ) _____
►Dentist Name _____ Phone ( ) _____

In case of emergency, the school will attempt to contact parent/guardian before calling a student's primary care provider (Physician). Your child will be transported by ambulance to an emergency care facility if necessary.

►Name(s) of designated adult(s) who will assume responsibility and/or transportation if parent unavailable.

Name _____ Relationship _____ Phone ( ) _____
Name _____ Relationship _____ Phone ( )_____

Insurance information: If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the School Nurse for more information. ALL communications will be confidential.

Does your child have Health Insurance? ___ Yes ___ No Company _____
Does your child have Dental Insurance? ___ Yes ___ No Company _____
Does your child have MassHealth? ____ Yes* ____ No Card # _____

****The Federal Government has ruled schools can be reimbursed through Medicaid for special Education services. (If applicable) I give permission to use the students MassHealth card # to bill Medicaid for the special education services rendered.***

Parent Signature _____ Date _____

I give my 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 give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

Parent Signature _____ Date _____

- **Medication Information: Under Massachusetts General Law (MGL Chapter 12), a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication, whether it is prescription or over-the-counter medication. Please contact the nurse for Medication Administration Permission Form .**

Please list medications child is presently taking at home as well as school;

_____ _____
_____ _____

Please check all that applies to your child:
[ ] Allergies (Food, insects, medication, environmental) _____
[ ] Heart Condition [ ] Diabetes [ ] Asthma [ ]Seizure disorder
[ ] ADD/ADHD [ ] Migraines [ ] Depression [ ] Other (specify) _____
[ ] Hearing problems Left ear _____ Right ear _____ Hearing aid(s) _____
[ ] Vision problems Wears glasses _____ Contact lenses _____
[ ] Needs preferential seating

Name/grade of sisters/brothers in Harvard Public Schools;

_____/_____ _____/_____
_____/_____ _____/_____

THANK YOU!