

Complete Both Sides

Lynn Public Schools
Emergency/Medical Form
School Year 2019/2020

ID: _____

School: _____ Grade/Home Room: _____ Shop: (if Applicable) _____

General Information

Student: _____ Birth Date: _____ Birthplace: _____
Last First Middle

Address: _____ Home Phone #: _____
Street Address Apt# City State/ Zip Code

Male [] Female [] Language spoken at home: _____ State Ward: []yes []no

Parent/Guardian

Name: _____ Relationship
Last First

Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Email Address: _____
Address if different from student: _____

Parent/Guardian

Name: _____ Relationship
Last First

Home Phone #: _____
Work Phone #: _____
Cell Phone #: _____
Email Address: _____
Address if different from student: _____

Student Sibling(s)

Name: _____ School : _____ Name: _____ School: _____

Name: _____ School : _____ Name: _____ School: _____

IF YOU ARE UNAVAILABLE: Emergency Contacts /Permission to Dismiss (must be 18 or over)

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

My Child May Not Be Dismissed To:

Name: _____ Relationship: _____

*Valid Restraining Order
[] Yes [] No

Name: _____ Relationship: _____

[] Yes [] No

(If yes, you must attach copy of order)

***Parent /Guardian Signature: _____

Complete Both Sides

STUDENT NAME: _____

HEALTH HISTORY

Do you have medical insurance?

Private Public (E.g., MA Health, Children’s Medical Security) No insurance

Name of Insurance Provider: _____ Group/Policy #: _____

(Please contact the school nurse if you need assistance applying for medical insurance)

Medical Information

Please **CHECK ALL BOXES** that apply to your child. Contact the school nurse for additional confidential medical information.

ALLERGIES (food, insects, medications, environment) _____ **Epi-Pen?** YES NO

Asthma ADD/ADHD Autism Bleeding/clotting problems Depression

Diabetes type I type II Heart defect/disease Kidney Disease

OTHER _____

History of concussion with date(s) _____

Convulsions/seizures (date of last seizure): _____ Type of seizure disorder: _____

Operations or serious injuries (dates) _____

Special medical equipment required _____

Vision Problems (specify) _____ Wears eyeglasses? YES NO Wears contacts? YES NO

Hearing Problems (specify) _____ Left ear Right ear Hearing aid ? ? YES NO

Date of last physical exam: _____ **Restrictions (doctor’s note required):** _____

(Copy/proof of physical required prior to school entry and in grades K, 4, 7 and 10. Please send to school nurse.)

Medication(s) your child is currently receiving:

At home: _____

At school: _____

Student’s Doctor/Pediatrician

Dental Care Provider

Name _____ Phone Number _____

Name _____ Phone Number _____

DO NOT LEAVE BLANK: PARENT AUTHORIZATION

YES NO 1. I give permission to the school nurse to disclose pertinent medical information based on his/her nursing assessment and judgment to those school employees involved directly with my child’s care and safety.

YES NO 2. I give permission for the school nurse to administer **Tylenol** to my child.

YES NO 3. I give permission for the school nurse to administer **Ibuprofen** to my child. (age 12 and over)

YES NO 4. I give permission for the school nurse to apply **Calamine** to my child for minor skin irritations.

YES NO 5. I give permission for my child to be transported to the hospital and receive medical attention in the event that I cannot be reached in an emergency

YES NO 6. This health history is correct as far as I know, and my child has permission to participate in all activities except as noted by me.

*****Parent/Guardian’s Signature** _____ **Date** _____