Foxborough Regional Charter School

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Child's Name_____ Date of Birth_____ Grade_____

Street Address _____ Town_____

Phone Number_____

Male_____ Female_____ Non-Binary_____ Primary Language_____

Is someone in your family presently serving in the Military? _____ Relationship? _____

Name / Age of Siblings_____

Mother /Guardian_____ Address_____ (If different from above)

Phone Number_____ Work Phone_____ Cell Phone_____

Email Address _____

Father/Guardian _____ Address_____ (If different from above)

Phone Number_____ Work Phone_____ Cell Phone_____

Email Address _____

<u>Name of others who will be responsible for your child:</u>

Name_____ Relationship _____ (Home) _____ (Cell) _____

Name_____ Relationship_____ (Home) _____ (Cell) _____

Physicians Name_____ Phone_____

Dentist Name_____ Phone_____ Dental Insurance_____

***Health Insurance Name and Policy number_____**

***My child does not have Health Insurance_____**
****If your child does not have 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 about these programs. All communication will remain confidential.**

Please list any medical conditions your child has_____
_____

Please list all medications your child takes_____
_____

******In case of emergency, the school will attempt to contact a parent/guardian before calling 911. Your child will be transported to an emergency care facility if needed.**

I give permission to the school nurse to share information relevant to my child's health condition with the 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/Guardian Signature_____ Date_____