EMERGENCY / NON-PRESCRIPTION MEDICATION FORM 2019-2020

(must be updated yearly)

HAMPDEN-WILBRAHAM REGIONAL SCHOOL DISTRICT

Dear Parent or Guardian:

Please fill in the following information and return it to school. This information is important in case of illness, medical emergency, or health related dismissal from school:

Name_____ Home Phone #_____
Last First Middle

Address_____ Town_____ZIP _____

Birth date_____ Birth Place_____ Grade _____Room Number _____

Parent/Guardian (Contact first) _____ Work # _____ Cell #_____

Parent/Guardian (Contact second) _____ Work # _____ Cell #_____

E-mail where parent/guardian may be reached during the day: _____

Student resides with: Parent Name _____ Parent Name_____ ☐...Both ☐...Other

If parent or guardian cannot be reached in an emergency, list names of adults to call who will assume responsibility and may pick up child.

Name _____ Phone #_____ Cell # _____

Name_____ Phone #_____ Cell # _____

Name_____ Phone #_____ Cell # _____

Student's Dentist_____ Phone #_____

Student's Physician_____ Phone #_____

State hospital preference, if necessary _____

Date of last physical exam _____

Health Insurance: Private _____MA Health_____None_____

I authorize the school nurse to contact my child's physician if I cannot be reached and such a call is considered necessary.

I give permission for the school nurse to give and/or receive immunization/ pertinent medical information from our child's health care providers.

In the event of an emergency, I give permission to the hospital or physician to provide emergency care for my child. If ambulance transport is necessary, parent/guardian is responsible for associated charges.

Signature of Parent/Guardian_____ ***Date***_____

OVER 

I give permission for the School Nurse to administer the following according to standing orders from School Physician (please check):

☐...Acetaminophen (Tylenol) ☐...Benadryl (emergencies only) ☐...Ibuprofen (Advil) ☐…Tums (antacid tablets)

☐...Calamine and/or Caladryl Lotion ☐...All of the above ☐...None of the above

Signature of Parent/Guardian_____ Date_____

ANNUAL STUDENT HEALTH SERVICES REPORT

Does your child have any **life** threatening allergies? YES / NO If yes to what?_____
Does your child have an EpiPen Yes/No (If yes, one should be provided to the health office with MD order and completed Allergy Action Plan form. Please get the Action Allergy Plan from the school nurse)
Other allergies: Food_____Medication_____Other_____
Does your child have asthma? Yes/No
Does your child use an inhaler for asthma? Yes/No Which Kind? Albuterol____Xopenex____Nebulizer____Other_____
(If your child uses a rescue inhaler one should be provided to the health office with MD order and completed Asthma Action Plan. Please get the Asthma Action Plan from the school nurse)

Please circle all chronic health/mental health conditions that your child has:

ADD/ADHD	Concussions (How many___)	Cancer	Hearing impairment/hearing aid
Autism	Frequent headaches	Diabetes	Vision impairment/**glasses/contact lenses**
PDD/NOS	Migraines	Scoliosis	
OCD	GERD/reflux	Kidney problem	
Anxiety	Nutritional/weight issues	Heart problem	
Depression	Dietary Restrictions	Seizure disorder	

Please include additional information about any items you circled: _____

_____

List all **prescription** medication taken at home by child _____

Will your child need to have prescription medication at school? Yes/No Please specify medication name:

_____

Medication administration at school requires a new written MD order and parental permission each school year. Please contact the school nurse for additional information and the proper form.

Is there any additional health information you would like to bring to the attention of the school nurse?

_____

_____

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 while at school.

Signature of Parent/Guardian_____ Date_____

Form rev. 02/2019