WESTON PUBLIC SCHOOL
ANNUAL NURSE EMERGENCY FORM

SCHOOL YEAR: _____ SCHOOL: _____ GRADE/TEACHER: _____

Student | Gender | Date of Birth

Home Address | Home Phone

Parent/Guardian Name

Parent/Guardian Home Address (including city/town and state) | Home Phone | Cell Phone

Parent/Guardian Business Address (including city/town and state) | Business Phone

Parent/Guardian E-Mail Address

Parent/Guardian Name

Parent/Guardian Home Address (including city/town and state) | Home Phone | Cell Phone

Parent/Guardian Business Address (including city/town and state) | Business Phone

Parent/Guardian E-Mail Address

Sibling's Name | Gender | Date of Birth | School

Sibling's Name | Gender | Date of Birth | School

Sibling's Name | Gender | Date of Birth | School

Emergency Numbers ***(person to call if parent/guardian cannot be reached):***

Name | Phone | Relationship

Name | Phone | Relationship

(PLEASE CONTINUE ON PAGE 2)

Student's Name

Doctor Phone

Dentist Phone

Orthodontist Phone

*Insurance Provider and Number

*If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care. Please contact the school nurse for more information. All communications will be confidential.

List Allergies: (Please circle life-threatening allergies)

Has your child been prescribed an EpiPen or EpiPen Jr.? (Please check yes or no) _____ Yes _____ No

Health Concerns: (including serious illness, accident, condition limiting full participation in school)

List All Medications:

Permission to Administer Medications:

Permission to administer over-the-counter medications (Tylenol, Ibuprofen, Benadryl, Antacids (Tums), Blistex, Calamine lotion and Vasoline) as prescribed by the School Physician ***requires annual*** parent/guardian signature:

Parent/Guardian Signature Date

Consent:

By my signature, I hereby consent to the disclosure of information contained on this form to Weston Public School personnel, medical professionals and others as deemed appropriate on a need to know basis 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 to meet my child's health and safety needs.

Parent/Guardian Signature Date