

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 Business Phone

Parent/Guardian Email 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 Cell Phone

Parent/Guardian Email 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(s) to call if parent/guardian cannot be reached*):

Name Phone Relationship

Name Phone Relationship

Student's Name _____

Doctor _____

Phone _____

Dentist _____

Phone _____

Orthodontist _____

Phone _____

*Insurance Provider _____

Member ID _____

*If you have no insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care. Please contact the school nurse for more information. All communication 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/sports) _____

List All Medications: _____

Permission to Administer Medications: Permission to administer ALL listed medications below _____ **Or** Permission to administer **only selected** medications: Antacids, Bacitracin, Benadryl, Blistex, Calamine Lotion, Cough Drops, Ibuprofen, Insect Repellent, Sunscreen, Tylenol, Vaseline, Zyrtec, 60% Hand Sanitizer

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 _____