Hudson Public Schools

Student Health Information

School Year_____

**** * Please complete accurately and return it promptly to the School Nurse as this may accompany your child if emergency care is needed.* ****

A school may disclose information regarding a student to appropriate parties in connection with a health or safety emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals. (Commonwealth of MA Regulations: 603 CMR 23.07) The school nurse may share health information that is necessary for the student's health and safety with authorized school personnel.

Student's Name _____ Grade _____ Teacher _____
Last First
Home Phone ( ) _____ Date of Birth _____ Language spoken at home:_____

Who does child live with? Both parents:_____ One parent_____ Parents share custody_____ Other (guardian)_____

Parent/Guardian Name_____ Cell phone ( ) _____

Employer _____ Work phone ( ) _____

Parent/Guardian Name_____ Cell phone ( ) _____

Employer _____ Work Phone ( ) _____

Parent Email Address_____ _____Check if school nurse may communicate by email

Siblings/School/grade _____

Emergency Contact Name **(must be other than Parent/Guardian)**_____ Relationship to child _____

Emergency Contact Home phone ( ) _____ Work phone ( ) _____ Cell phone ( ) _____

Physician/Health Care Provider _____ Phone ( ) _____

Does your child have Health Insurance? ☐ No ☐ Yes Does your child have Mass Health? ☐ No ☐ Yes
Does your child have Dental Insurance? ☐ No ☐ Yes ***If your child does not have health insurance, please contact the School Nurse who will provide you with information.***

Please list medications your child regularly takes at home or school _____

If your child requires medication or special care at school, please contact the nurse. A signed order from a licensed prescriber and written parental permission is required for medicine or treatment given at school (except as noted below).

Please place an "X" in the box below for all that apply to your child.		If your child sees a Specialist for a health condition, please write the Specialist's name below:
	Severe Allergy **requiring Epipen** (for example food, insects) _____	
	ADD/ADHD	
	Allergies – other _____ **Not requiring EpiPen**	
	Asthma	
	Concussion History- Medically diagnosed: How many?	
	Dental/Teeth Concern	
	Diabetes	
	Emotional, behavioral or mental health concerns	
	Hearing problem: _____ Right ear _____ Left ear	
	Heart Condition	
	Migraines (confirmed by medical provider)	
	Seizures	
	Vision problem: _____ Glasses _____Contacts	
	Other health condition – specify _____	

● *I give permission for the School Nurse to administer the following medication to my child for the duration of this school year:*

Indicate by placing a "X": ☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Motrin/Advil) ☐ Diphenhydramine (Benadryl)
☐ Skin application of calamine or caladryl lotion

Parent Signature _____ Date _____

**** * * Please return this promptly to the School Nurse * * ****