



GREENFIELD PUBLIC SCHOOL

195 Federal Street, Suite 100, Greenfield, MA 01301

“Every Child’s Success is Our Mission”

Ph: 413-772-1300 / Fax: 413-772-1379

HEALTH/MEDICAL INFORMATION and Permission to Treat

For School Nurse’s Record

FIRST NAME:	MIDDLE NAME:	LAST NAME:
DOB: _____	GRADE: _____	GENDER: MALE _____ FEMALE _____ NON-BINARY _____
HOME ADDRESS:		
Parent/Guardian #1: _____	Phone: (H) _____	(cell) _____
Parent/Guardian #2: _____	Phone : (H) _____	(cell) _____
Student lives with: Both Parents _____ One Parent (specify): _____ Other (specify): _____		
Student’s Legal Guardian: Both Parents: _____ Guardian (specify): _____ Other (specify): _____		
Pediatrician’s Name _____ Dentist Name _____		
<p>Has your child had a routine physical examination within the last 12 months? YES / NO (If your child is in Pre-K, K, grades 4, 7, 10 or new to the school district, please be sure to forward a copy of the most recent physical examination to the school nurse).</p>		

Has your child been diagnosed with any of the following health conditions:

	YES	NO	If YES, please describe:
ASTHMA			INHALER?
DIABETES			IF YES, SEE SCHOOL NURSE FOR CARE DETAILS PRIOR TO START OF SCHOOL.
ADD/ADHD			MEDICATION?
SEIZURE DISORDER			MEDICATION?
BLEEDING DISORDER			
SKIN CONDITION			
EYE/VISION PROBLEM			DO THEY WEAR GLASSES? FOR READING, DISTANCE OR BOTH?
EAR/HEARING PROBLEM			
FOOD ALLERGY			
SEASONAL ALLERGIES			
INSECT ALLERGY			
MIGRAINES			
DEPRESSION			
OTHER (SPECIFY)			

If your child is taking any medications other than what you have listed above, please provide medication name and reason for use: _____

<p>Does your child have health insurance? Please circle: Yes / No Health Insurance Company:</p>																
<p>Physician's Information: Please provide your family physician's name and phone number.</p>																
<p>If your child has allergies, do they require an EPI-PEN? YES / NO</p>																
<p>Please add any other problems or comments you like to bring to the attention of the school nurse or physician. Please include any significant accidents, illnesses, surgeries, and or losses (death in family, a move, divorce, etc.) in recent months that may affect your child's school experience.</p>																
<p>I give permission for the school nurse to administer the following medication (s) to my child: (Please circle yes or no)</p> <table> <tr> <td>Yes / No Ibuprofen</td> <td>Yes / No Benadryl</td> <td>Yes / No Tums</td> <td>Yes / No Cough Drops</td> </tr> <tr> <td>Yes / No Tylenol</td> <td>Yes / No Calamine</td> <td>Yes / No Bacitracin</td> <td>Yes / No Anbesol</td> </tr> <tr> <td>Yes / No Bactine</td> <td>Yes / No Aloe Gel</td> <td>Yes / No Sting Eze</td> <td>Yes / No EpiPen</td> </tr> <tr> <td>Yes / No First Aid Cream</td> <td></td> <td></td> <td></td> </tr> </table>	Yes / No Ibuprofen	Yes / No Benadryl	Yes / No Tums	Yes / No Cough Drops	Yes / No Tylenol	Yes / No Calamine	Yes / No Bacitracin	Yes / No Anbesol	Yes / No Bactine	Yes / No Aloe Gel	Yes / No Sting Eze	Yes / No EpiPen	Yes / No First Aid Cream			
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I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. **Yes / No**

I give permission to the school nurse to exchange information with my child's physician for the purpose of referral, diagnosis and treatment. **Yes / No**

If emergency treatment is immediately required, the school nurse and/or school administration will exercise their own judgment in calling 911 to transport the child to a hospital emergency department. Every effort will be made for prompt communication with the parent or guardian if this situation occurs.

EMERGENCY INFORMATION:

If my child becomes ill at school and requires dismissal, and the parent or guardian can not be reached, you are authorized to call the following individuals who will assume responsibility and arrange transportation. You may also release the reason for dismissal to the following individuals.

1. Name:	Relationship:
Phone:	Mobile:
2. Name:	Relationship:
Phone:	Mobile:
3. Name:	Relationship:
Phone:	Mobile:

Signature of Parent / Guardian: _____ Date: _____

Signature of Parent / Guardian: _____ Date: _____

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