



SCHOOL NURSE
HEALTH INFORMATION
2016-2017

In order to provide a safe and healthy environment for your child this confidential information will be accessible to: School Nurse, applicable school staff & emergency medical personnel.

Name: _____ Birthdate: _____ Sex: M/ F _____
School: _____ Grade: _____ Date: _____

SERIOUS HEALTH CONDITIONS (check appropriate box below)

If your child has a serious medical condition, it is vital that you discuss this with your School Nurse immediately. Massachusetts General Laws, chapter 30A, section 8 and chapter 112, section 80B requires medication and/or treatment orders, medications and health care plan be in place PRIOR to the start of school.

- My child does not have any serious health conditions that will affect him/her at school.
My child has the following serious health condition(s) - Check boxes below:
Allergy (life threatening - requires an epinephrine prescription such as Epinephrine Auto Injector).
Asthma - Will your child require a rescue inhaler (such as Albuterol) at school?
Cardiac diagnosis:
Restrictions:
Diabetes (Date of diagnosis:) Type 1 Type 2
Insulin Pump Insulin Pen Insulin via syringe
Seizure Disorder (Date of diagnosis:) (Date of last seizure:)
Type: Rescue Medication: Yes or no?

OTHER HEALTH CONDITIONS (check appropriate box below):

- My child does not have any other health conditions that will affect him/her at school.
History of a Concussion (diagnosed by a licensed health care provider) - Date of concussion
Hearing concerns? Does your child wear hearing aids? Does your child have a known hearing loss?
Vision concerns? Glasses Contacts
ADD/ADHD Autism Bleeding/Clotting problems Depression Kidney Disease Other

Is there any medical or emotional condition that the school should be aware of?
Is there any family situation (example: military deployment, separation, recent death) that the school should be aware of?

MEDICATIONS: Prescription, supplements, over-the-counter (eye drops, ointments, etc):

Medication(s) your child is currently receiving:
Does your child require medication at school on a regular or as needed basis? Yes No

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.
I give permission to the School Nurse to exchange information with my child's health care providers for the purpose of referral, diagnosis, and treatment.

Parent/Guardian, please print _____

*Signature (Parent/Guardian): _____ Date: _____