Weymouth Public Schools Health Services

Confidential Health Form

Student:_____Phone_____
Address:_____Grade:_____
State/Zip:_____ DOB:_____

Custodial Parent/Legal Guardian
Name:_____Relationship:_____
Work Phone:_____Cell Phone:_____

Custodial Parent /Legal Guardian
Name:_____Relationship:_____
Work Phone:_____CellPhone:_____

Custodial Restrictions: _____

Non-Custodial Parent/Adult: Allow to pick up? __ Yes or __No

First name Last name:_____ Relationship:_____
First name Last name:_____ Relationship:_____

Emergency Contacts
Name:_____ Relationship: _____
Phone:_____

Name:_____ Relationship: _____
Phone:_____

Name:_____ Relationship: _____
Phone:_____

Name:_____ Relationship: _____
Phone:_____

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MEDICAL INFORMATION

Physician's Name:_____ Address:_____

Phone:_____

Health Insurance:_____ Policy #:_____

Dentist Name:_____ Address:_____

Phone:_____

Dental Insurance:_____ Policy #:_____

DATE OF RECENT PHYSICAL EXAM:_____ DATE OF RECENT DENTAL EXAM:_____

I give permission for the School Nurse to share medical information with the appropriate school personnel; to contact my child's physician as necessary, and for the school personnel to have my child transported to the hospital emergency room for treatment in the event of an emergency if I cannot be contacted.

Electronic Signature of Parent/Guardian:_____Date:_____

IF YOU HAVE NO HEALTH INSURANCE, THE COMMONWEALTH OF MASSACHUSETTS HAS A HEALTH INSURANCE PLAN THAT WILL PROVIDE UNINSURED CHILDREN WITH AFFORDABLE HEALTH CARE. IF YOU ARE INTERESTED IN INFORMATION ABOUT THIS PROGRAM, PLEASE CONTACT YOUR SCHOOL NURSE.

All students in grades 1, 4, 7, and 10 will have height and weight measured and their body mass index calculated in accordance with Massachusetts Department of Public Health guidelines. If you do not want your child to participate please send a written notification to the school nurse.

I give the school nurse permission to give my child age appropriate dose of *Acetaminophen (Tylenol) (YES) (NO) or *Ibuprofen (Motrin) (YES) (NO) according to the district's standing orders.

Pre-school excluded

***Ibuprofen is only administered in grades 5-12**

Signature of Parent/Guardian:_____DATE:_____

Weymouth Public Schools Health Services

Confidential Health Form-continued

Check if your child wears: Glasses __Contacts___Hearing Aids__Assistaive devices___

Does your child have any allergies (medications, food, bees/insects, environmental)?_____

If yes, does your child have an Epi-Pen? _____

Please list all allergies and your child's individual reaction symptoms:
_____
_____

Date of last reaction and treatment needed: _____

Have you returned an updated allergy emergency action plan, for this year, to the health office? (Yes) (NO)

Does your child have any medical/mental health conditions that health services should be aware of to assist your child to be safe and succeed in school? i.e. Diabetes, Asthma, Seizures, Heart Condition, Colitis, Arthritis, ADHD, Bipolar, Anxiety, Depression, etc.

(YES) (NO)---- if YES, please list all:_____
Please explain: Condition:_____When Diagnosed: _____

Symptoms your child may have that would alert us that he/she is having a problem related to his/her condition:
_____
_____

Please list all medications and dosage that your child takes on a regular basis during school or outside the school _____

Is there any other information that would be helpful to know about your child_____