WEYMOUTH PUBLIC SCHOOLS – CONFIDENTIAL HEALTH FORM

PLEASE COMPLETE BOTH SIDES AND SIGN

Phone _____ Student Name _____

Grade _____HR _____ Address_____

DOB_____ Zip _____

Custodial Par/Grdn FN LN: _____Relationship_____WkCity _____

Work Phone: _____X_____Cell Phone: _____ Email: _____

Custodial Par/Grdn FN LN: _____Relationship_____WkCity _____

Work Phone: _____X_____Cell Phone: _____Email: _____

Non-Custodial Parent/Adults(s) (Please check as desired) _____Allow Pickup? _____Emergency Contacts?

Name: _____ Relationship _____Phone: _____

Name: _____ Relationship _____ Phone: _____

Emergency Contacts – SAME as on white office copy, please (minimum 2):

Name: _____ Relationship _____Phone: _____

Name: _____ Relationship _____Phone: _____

Name: _____ Relationship _____Phone: _____

Name: _____ Relationship _____Phone: _____

Custodial Restrictions: _____

MEDICAL INFORMATION

Physician's Name_____Address_____Phone#_____

Health Insurance_____Policy Number_____No Insurance____

Dentist's Name_____Address_____Phone#_____

Dental Insurance_____Policy Number_____No Insurance____

DATE OF MOST RECENT PHYSICAL EXAM_____DATE OF MOST 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.

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 written notification to the school nurse.

I give the school nurse permission to give my child age appropriate dose of Acetaminophen (Tylenol) ___or *Ibuprofen (Motrin)___according to the district's standing orders. (CHECK ONE, BOTH, OR NONE.) Pre-school excluded.

*Ibuprofen is only administered in grades 5-12

Signature of Parent/Guardian_____Date_____

Weymouth Public Schools Health Services
Student Health Update

******Confidential Information please return to the Health Office******

Does your child have any **allergies** (medications, food, bees/insects, environmental)?
Yes □ No □ If yes, does your child have an Epi-Pen? Yes □ No □
Please list all allergies and your child's individual reaction symptoms:

_____
_____
_____
_____
_____
_____

Date of last reaction and treatment needed:

_____
_____
_____
_____

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? such as Diabetes, Asthma, Seizures, Heart Condition, Colitis, Arthritis, ADHD, Bipolar, Anxiety, Depression etc... Yes □ No □
Please explain: Condition:_____ When Diagnosised:_____
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 and outside the school day.

_____
_____
_____
_____

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

_____
_____
_____

Feel free to contact your child's school nurse with questions or concerns anytime during the school year.
Thank you

Revised July 2014