

FRONT OF CARD

Pentucket Regional Schools Confidential Emergency Health Information Card

Student's name _____ **Grade** _____
Last First M.I.

Address _____ Date of Birth _____

Male ___ Female ___ Primary Language _____ Resides with _____

Home Telephone # _____

Mother's Name _____ **Work #** _____ **Cell Phone #** _____

Father's name _____ **Work #** _____ **Cell Phone #** _____

Does your child have Health Insurance? Yes ___ No ___

Health Insurance Co. _____ Policy Number _____

If there is someone your child should not be dismissed to, note here _____

****If you have no health insurance, Massachusetts has health insurance plans available that will provide uninsured children, up to the age of 19, with affordable health care (restrictions may apply). Please contact your school nurse for more information about these programs. All communications are **confidential**.*

Name/grade of brothers/sisters in Pentucket Schools _____

In case of an emergency situation/illness and the school nurse is unable to reach the contacts listed above, please call the following contacts who will assume responsibility/transportation for my child:

Name _____ **Relationship** _____ **Telephone #** _____

Name _____ **Relationship** _____ **Telephone #** _____

BACK OF CARD

In case of an emergency, the school will attempt to contact the parent/guardian listed above before calling the student's Primary Care Provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary. Please provide the following information: Physician's Name _____ Telephone# _____

Dentist's Name _____ Telephone # _____

How often does your child see the dentist? _____ Every 6 mths _____ 1x per year

Please list all medications your child takes: _____

Please check all that apply to your child:

Heart condition _____ Diabetes _____ Asthma _____ Seizure Disorder _____ ADD/ADHD _____

Migraines _____ Depression _____ Freq. Ear Infections _____ Kidney Disease _____

Rheumatic fever _____ Speech/Hearing/Vision Problems (specify) _____

Anxiety Disorder or other mental health concerns (specify) _____

ALLERGIES- Specify-food, insect, environmental _____

Other-Specify _____

Does your child need an Epi-pen for the allergy specified above? _____ Yes _____ No

I give the school nurse permission to give my child Tylenol, Ibuprofen, cough drops, Benadryl, and Tums _____ 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 for the school nurse to contact and exchange information with my child's physician for the purpose of referral, diagnosis and treatment. My child has my permission to receive health/wellness and support services offered in the health office.

Signature of parent/guardian _____ Date: _____