

**EMERGENCY CONTACT / MEDICAL INFORMATION
Chelmsford Community Education / Elementary Students**

PRIMARY SCHOOL _____ PROGRAM(*If CommEd*) _____ GRADE _____ TEACHER _____

CHILD'S NAME _____ DOB _____ AGE _____ BUS # _____

GENDER _____ EYE COLOR _____ HAIR COLOR _____ HEIGHT _____ ft. _____ in. WEIGHT _____ lbs.

IDENTIFYING MARKS _____

Are there any custody concerns regarding this child? *YES _____ NO _____

**In order to comply appropriately, the proper legal documentation must be received by the elementary school office and Chelmsford Community Education if program is used.*

CHILD'S ADDRESS _____
Number and Street Town State Zip

WHO DOES THE CHILD LIVE WITH _____

MOTHER/GUARDIAN'S NAME _____ HOME PHONE (____) _____

HOME ADDRESS _____ CELLULAR (____) _____
Number and Street Town State Zip

PLACE OF EMPLOYMENT _____ WORK PHONE (____) _____

FATHER/GUARDIAN'S NAME _____ HOME PHONE (____) _____

HOME ADDRESS _____ CELLULAR (____) _____
Number and Street Town State Zip

PLACE OF EMPLOYMENT _____ WORK PHONE (____) _____

PRIORITIZE # FOR QUICK CONTACTING (Call 1st, 2nd etc...)

MOTHER's	(H)	(W)	(C)
FATHER's	(H)	(W)	(C)

*SIBLING INFORMATION – If applicable, please list all siblings, ages, and current schools

If parent/guardian not available, list the persons you wish to be called and authorized to pick up your child:

Name _____ Relationship _____ How refers to individual _____

Contact numbers _____

Name _____ Relationship _____ How child refers to individual _____

Contact numbers _____

Name _____ Relationship _____ How child refers to individual _____

Contact numbers _____

Please complete the following if your child goes to a day care/babysitter's part time or every day:

NAME _____ ADDRESS _____ PHONE (____) _____
Number and Street Town State Zip

DAYS WITH DAY CARE/SITTER Monday Tuesday Wednesday Thursday Friday

Parent/Guardian's Signature: _____ **Date:** _____

THIS IS A TWO SIDED FORM

HEALTH INFORMATION

CHILD'S NAME _____ DOB _____ WEIGHT _____ lbs. GR _____ TEACHER _____

DESIRED HOSPITAL _____

DOCTOR	LOCATION	PHONE () -
EYE DOCTOR	LOCATION	PHONE () -
DENTIST	LOCATION	PHONE () -

*HEALTH INSURANCE _____ DENTAL INSURANCE _____
**If none write "None". The school nurse is available to assist families locating free and or reduced cost insurance .*

If needed, I give permission to the nurse to administer and/or apply the following medications that have been approved by our school physician: acetaminophen(Tylenol), Caladryl, Oragel, Vaseline, Ibuprofen (Motrin/Advil), saline eye solutions, Bacitracin, Silvadene Cream, hydrocortisone cream, diphenhydramine(Benadryl), and First Aid Cream? _____

Yes No

Comments/Notes _____ (Parent/Guardian's Signature **required**) (Date)

If needed, I give permission to the nurse to share the following information with the appropriate school personnel to meet my child's health, safety, and/or educational needs?

Yes No

Comments/Notes _____ (Parent/Guardian's Signature **required**) (Date)

I give permission to the nurse to speak with the above listed doctor to meet my child's health and safety needs.

Yes No

Comments/Notes _____ (Parent/Guardian's Signature **required**) (Date)

Allergies: My child has no allergies My child has the following allergies **Is an Epi-pen Prescribed?** *Yes No

*Foods child is allergic to: _____ **Environmental** _____

*Medication _____ *Bee/Insect _____ *Latex _____ **Other _____

****Each school year, an Allergy Medication Plan and Consent Form is required. If no medications are needed at school, then documentation from the doctor indicating such is required.***

Check all conditions that apply:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney	<input type="checkbox"/> Strep throat infections (history of)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Developmental Delays	<input type="checkbox"/> Lactose Intolerant	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Migraines	Hospitalizations this year? Yes <input type="checkbox"/> No <input type="checkbox"/> Reason? _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eyeglasses/Contacts	<input type="checkbox"/> Nosebleeds	
<input type="checkbox"/> Autism spectrum	<input type="checkbox"/> Gastric reflux	<input type="checkbox"/> Reflux (other)	Previous Concussions? Yes <input type="checkbox"/> No <input type="checkbox"/> Dates _____
<input type="checkbox"/> Bladder Control	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Seizures	<input type="checkbox"/> Emotional Concerns? _____ _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Scoliosis	
<input type="checkbox"/> Celiac	<input type="checkbox"/> Heart Murmur		

Is an inhaler and/or nebulizer prescribed for your child? Yes No Will it be sent to school? Yes No
 Will it be sent to Community Education ? Yes No

Medications: Does your child take any daily or as needed medications at home? Yes No **if yes, please list*

Medication: _____	Time of Day: _____	Dose: _____	Required during school hours? Yes <input type="checkbox"/> No <input type="checkbox"/>
Medication: _____	Time of Day: _____	Dose: _____	Required during school hours? Yes <input type="checkbox"/> No <input type="checkbox"/>
Medication: _____	Time of Day: _____	Dose: _____	Required during school hours? Yes <input type="checkbox"/> No <input type="checkbox"/>

Medications necessary to be given during the school day and/or the CommEd Childcare programs, must submit to both offices: 1) written physician's order, 2) written parental permission, and 3) be supplied and delivered by parent in the original labeled container.

Please list any other medical, emotional, health concerns/issues and/or past medical problem that limits activity at school or can help the School Nurse care for your child: _____

Parent/Guardian's Signature: _____

Date: _____