



STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Parent/Guardian: please complete, sign, and return to Health Office. Any concerns, call 978-373-4101X221.

Student's Legal Name: Last	First	M.I.	Grade:
Student's Address:	City:	State:	Primary Language:
Does student live with parent? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, provide name/relationship of guardian)		Any siblings at Whittier? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: _____ Grade: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: / /	Which health insurance does your child have? Private <input type="checkbox"/> No insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> SCHIP <input type="checkbox"/> Commonwealth Care <input type="checkbox"/>	

Contact and Emergency Information

Parent/Guardian Name	Home Phone	Work Phone	Cell Phone	Authorized Pick-up	Legal Custody
Parent/Guard. #1 Address if different				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Parent/Guard. #2 Address if different				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If parent/guardian cannot be reached, please notify the person(s) below in case of an emergency:

Emergency Contact (Name/Relation)				Yes <input type="checkbox"/> No <input type="checkbox"/>	
Emergency Contact (Name/Relation)				Yes <input type="checkbox"/> No <input type="checkbox"/>	

List any medications taken on a regular basis:

Medication Allergies _____

Physician diagnosed allergies:

Nuts _____ Bees/Insects _____

Food _____

Describe reaction _____

Requires life saving medications? Yes No

What medications? _____

If prescribed, you must provide the school with EpiPens.

Check all that apply: Asthma Diabetes Type 1

Diabetes Type 2 Heart Condition _____

Migraines Seizures Depression Anxiety

ADD ADHD Bipolar Asperger Syndrome

Autism Other _____

Hearing problems: left right deaf hear aids

Vision problems: glasses contacts blind

Illness/Injury since last year?

Last physical exam? _____ **(please send copy)**

Student's MD _____ Ph _____

Student's Dentist _____ Ph _____

Prescription medications needed during school hours require written doctor's order, written parent permission and original container.

Over the counter medications require written parent permission and student's own original container.

Parent/Guardian:

Print Name

Signature

Date