Lowell Public Schools

MEDICAL EMERGENCY FORM

(Return to School Nurse)

Grade:_____

Homeroom:_____

Student: _____ Date of Birth: _____ Gender : M/ F

Address: _____ Home Phone #:_____

Parent/Guardian #1 Name: _____ | Parent/Guardian #2 Name: _____

Parent/Guardian #1 Cell:_____ | Parent/Guardian #2 Cell:_____

Parent/Guardian #1 Work #:_____ | Parent/Guardian #2 Work #:_____

Student's Physician:_____ Telephone # _____

List 3 local adults (other than parent/guardian) who will assume immediate care of your child and pick up your child at school in the event of illness or emergency:

Name:_____ Tel: _____

Name: _____ Tel: _____

Name: _____ Tel: _____

Circle all current health conditions that apply to your child:

ADHD Anxiety Asthma Autism/PDD Cerebral Palsy Depression Diabetes Heart Condition

Lactose Intolerance Migraines Seizure Disorder Sickle Cell OTHER (please list)

_____

Allergies (please list): _____

Is your child prescribed an **Epi pen** for treatment of the allergy listed above? Yes No

Vision Problems (specify):_____ glasses ____ contacts _____

Hearing Problems (specify): Left _____ Right _____ Hearing aids: Left _____ Right_____

List medication and dosage taken by your child on a regular basis or as needed: _____

_____

Does your child have health insurance? Yes No MassHealth ? Yes No

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel as needed to meet my child's health and safety needs.

In case of emergency, your child will be transported to the hospital by EMS.

I hereby authorize the school nurse to contact my child's physician if necessary.

Signature of Parent/Guardian _____ Date _____