

**EASTHAMPTON PUBLIC SCHOOL DISTRICT**  
**HEALTH SERVICES**

*Dear Parent or Guardian. Please completely fill in the following information and return it to school with your child. This information is important in case of illness, emergency, during an after-school athletic program, or emergency dismissal from school. (One sheet per child.)*

Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_  
Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ Town \_\_\_\_\_ Mailing \_\_\_\_\_  
Parent #1 \_\_\_\_\_ Business Phone# \_\_\_\_\_  
Parent #2 \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Guardian \_\_\_\_\_ Beeper # \_\_\_\_\_

If parent cannot be reached in an emergency, names of responsible adults to call who may pick up child:

Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Student's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Has student been seen by his/her physician if in the last two years? \_\_\_\_\_ Date: \_\_\_\_\_

Student's Health Insurance Carrier \_\_\_\_\_ Insurance Policy # \_\_\_\_\_

Do you need assistance in obtaining health insurance for your child \_\_\_\_\_ Yes

**ANNUAL STUDENT HEALTH SERVICE REPORT**

Does student have any chronic health conditions? \_\_\_\_\_

STUDENT IS ALLERGIC TO: \_\_\_\_\_

Are allergy injections being administered NO \_\_\_\_\_ YES \_\_\_\_\_ By Whom \_\_\_\_\_

Does student have difficulty concentrating? \_\_\_\_\_

Restrictions: Classroom \_\_\_\_\_ Physical Education \_\_\_\_\_ Glasses/Contacts \_\_\_\_\_

Any illnesses, injuries or surgery since last school year? \_\_\_\_\_

\_\_\_\_\_

List any medication taken at home on a regular basis or when necessary and reasons for medication.

\_\_\_\_\_

Any additional information school should be aware of:

**Permission to administer standing order medications:**

I give permission to have the school nurse, or school personnel delegated by the nurse (if applicable), to administer the following: (Doses determined by age and weight)

\_\_\_\_ All of the following    \_\_\_\_ Acetaminophen (Tylenol)    \_\_\_\_ Ibuprofen (Advil)    \_\_\_\_ Benadryl  
\_\_\_\_ None of the following    \_\_\_\_ Calamine Lotion    \_\_\_\_ Cough Drops    \_\_\_\_ Bacitracin Ointment  
\_\_\_\_ Throat Lozenges

I hereby authorize you to call my family physician if I cannot be reached and such a call is considered necessary.

Signature of parent/guardian \_\_\_\_\_

**PLEASE RETURN THIS FORM TO SCHOOL NURSE AS SOON AS POSSIBLE.**

Your input will help us to provide a safe environment for your child. Thanks