Ayer Shirley Regional School District
Health and Emergency Information Form

The following information is requested of the parent/guardian in order for your child to receive prompt notification, and for your child to receive prompt attention in the event of serious illness or injury. These records will be kept in the health office and remain confidential.

Student Information	
Child's Name:	Date of Birth:
Grade:	Teacher/Advisor (new registrations leave blank):
Your child resides with: ____ mother ____ father ____ both parents ____ guardian/other	
Guardian 1 Name:	Home Phone:
Address:	Work Phone:
Email:	Mobile Phone:
Guardian 2 Name:	Home Phone:
Address:	Work Phone:
Email:	Mobile Phone:
Sibling(s) in the Ayer Shirley Regional School District	
Name:	School:
Name:	School:
Name:	School:
Name:	School:

Emergency Contact(s): If unable to reach a parent/guardian, please list the names of persons you wish to be called.	
Name:	Phone:
Name:	Phone:
Name:	Phone:

Medical Information	
Your child's doctor:	Phone:
Your child's dentist:	Phone:
Medical Insurance (please select one): ____ Children's Medical Security Plan ____ Mass Health ___ Private Insurance	
ALL CHILDREN IN MASSACHUSETTS QUALIFY FOR HEALTH INSURANCE. Massachusetts health insurance plans that provide uninsured children with affordable health care are available (restrictions may apply). Contact the school nurse for more information about these programs. All communication is confidential. Would you like information about MassHealth? Yes ____ No ____	

Do you give permission for the following medications to be administered by the nurse to your child as needed? Check all that apply:

____ Acetaminophen (Tylenol) ____ Ibuprofen (Advil) ____ Tums ____ Hydrocortisone Cream

____ Benadryl ____ Orajel ____ Burn free gel ____ Calamine Lotion

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Medical History:
Is your child being treated for any of the following conditions?

_____ ADD/ADHD _____ Seizure Disorder _____ Eye problems

_____ Kidney disease _____ Diabetes _____ Heart Condition

_____ Scoliosis _____ Arthritis _____ Headaches

_____ Depression _____ Anxiety _____ Bipolar Disorder

_____ Asthma (If yes, explain triggers and treatment)

_____ Food AllergiesIf yes, describe reaction and treatment

_____ Stinging Insect Allergy (If yes, describe reaction and treatment)

Other allergies: Specify reaction and treatment

Has your child ever been diagnosed with a concussion? _____ When?_____

Does your child wear eyeglasses? YES _____ NO _____
Does your child have hearing loss? YES _____ NO _____

Does your child take any medication on a regular basis? If yes, for what reason? List medication(s):

1. Medication _____ Reason _____
2. Medication _____ Reason _____
3. Medication _____ Reason _____

If your child receives any immunizations during the school year, please submit documentation for your child's health record at school. After a Physical Exam or vaccine administration is performed, Physician Office's do not send this information to the schools, it is the parents responsibility to submit it to your child's school.
Initial : _____

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. I give permission to exchange information with my child's healthcare provider. I understand that I can limit or revoke this consent at any time.

Parent/Guardian's Signature_____ Date _____