Boston Collegiate Charter School
Health/Office Emergency Card for the 2017-2018 School Year

Please complete and return this form to the school nurse ASAP. This form is valid for the 2017-2018 only.

This form is double sided, please fill out both sides.

THIS INFORMATION IS IMPORTANT IN CASE OF ILLNESS, EMERGENCY, OR UNSCHEDULED DISMISSAL FROM SCHOOL.

Student Name ____ Date of Birth ____________ Entering Grade _____

Address ____ Zip ____________

Mother's Name ____ Best Telephone __________________________

Mother's Employer ______________________________________ Work Telephone __________________________

Father's Name ____ Best Telephone ___________________________

Father's Employer ______________________________________ Work Telephone __________________________

<u>Best Contact during School hours:</u>

Name ______________________________ Phone _________________ Relationship to student _____________

Primary language spoken at home: ❑ English ❑ Spanish ❑ Other: ______________________________

Is there any custody issues of which the school should be aware? If so, please explain.

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In the event that a parent/guardian cannot be reached in an emergency or in the case of illness, please list <u>two</u> responsible adults to contact.

Name ___________________________________ Relation __________________ Telephone __________________

Name ___________________________________ Relation __________________ Telephone __________________

If emergency medical attention is necessary and we cannot reach you, do you authorize school staff to initiate medical treatment? (Please check one) Yes ❑ No ❑

Hospital where you take your child if he/she is ill: ____

<u>Health Insurance Information:</u>

Name of Insurance Company: ______________________________ Policy Number: __________________________

Doctor's Name: ____ Doctor's Telephone: _______________________

Dentist's Name: ____ Dentist's Telephone: ______________________

<u>'Over The Counter' Medication Administration Permission</u>

The school physician allows the school nurse to administer the Over the Counter (OTC) medications listed below. Any other medications require a physician's order.

My child has permission to take the following OTC medications (please check):

Acetaminophen (Tylenol) Yes ❑ No ❑	Allergy Relief (Benadryl) Yes ❑ No ❑
Ibuprofen (Motrin/Advil) Yes ❑ No ❑	Antacid (Tums/Rolaids) Yes ❑ No ❑

Please note: The school nurse may use first aid treatments, including topical ones, to treat allergic rashes, insect bites, toothaches, minor-wound infections and minor burns unless otherwise indicated by parent/guardian.

Parent/Guardian Signature: ____ Date: __________

<u>Prescribed Medications:</u> Please list prescription and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School*

***Note: All prescription and some over-the-counter medications which your child must take at school require an MD/NP written prescription letter to keep on file at school. Please see attached form.**

<u>Health History: Life Threatening and Other Allergies</u>

Indicate if your child has a *physician verified* allergy. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the school nurse. *Written prescriptions are required for all Epi Pens, Benadryl and Inhalers.*

❑ Bee Stings	❑ Specific Food(s), specify:
❑ Peanuts	❑ Medication(s), specify:
❑ Tree Nuts	❑ Other, specify:
❑ Lactose Intolerance	❑ Seasonal/Environmental, specify:

Describe your child's allergic reaction symptoms: ______________________________

Indicate treatment for allergic reaction at school:______________________________

***If your child has any life threatening allergies, please attach Emergency Care Plan.*

***Is Epi Pen* required?** ❑ **Yes** ❑ **No**
Has Epi Pen ever been used? ❑ Yes ❑ No
Does your child carry his/her own Epi Pen? ❑ Yes ❑ No

Is Benadryl required? ❑ Yes ❑ No
Has Benadryl ever been used? ❑ Yes ❑ No
Asthma inhaler (see form) ❑ Yes ❑ No

<u>Illness/Chronic Conditions</u> - Does your child currently have any of the following illnesses or conditions?

❑ Asthma	❑ Braces/ orthodontics	❑ Urinary Problems
❑ G6PD	❑ Sickle Cell	❑ Skin Problems
❑ Diabetes	❑ Bone/Joint Problems	❑ Anemia
❑ Seizures	❑ Heart Problem	❑ Vision: Eyeglasses/ contact lenses
❑ Bowel Problems, Specify Below:	❑ Other Dental, Specify Below:	❑ Other, Specify Below:

Please list any illnesses your child is being treated for: ______________________________

Has your child had surgery or major injuries in the last year? Specify: ______________________________

Does your child have any dietary or physical limitations: ______________________________

(Please note that a note from your child's physician is required to excuse a child from school activity, including physical education, and for frequent restroom use.)

Is there any information about your child's physical or emotional status to help us make their education more productive? ______________________________

<u>Other Health Information:</u>

Please identify any other health concerns you have for your child that you would like the school nurse to be aware of. If you would like the school nurse to contact you to discuss your child's health concerns, please state so below:

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Confidential Information I grant permission to the school nurse to share health information about my child, on a need to know basis, with his/her teachers and coaches. Yes ❑ No ❑

Health Care Provider Release I grant the school nurse permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time. Yes ❑ No ❑

Parent/Guardian Signature: ______________________________ **Date:** ___________