



Confidential Health Form

For 2011-2012 School Year

Students Name: _____
Date of Birth: _____ Grade: _____ Teacher: _____
Mother's Name: _____ Father's Name: _____
Address: _____
Resides with: _____ Home Phone #: _____
Mother's home phone: _____ Work phone: _____
Father's home phone: _____ Work phone: _____
Mother's cell phone: _____ Father's Cell Phone: _____
Names and ages of student's siblings: _____

Primary Care Physician: _____ Phone #: _____
Does your child have health insurance? Yes _____ No _____
Name of Provider: _____ Provider #: _____
(Massachusetts has health insurance plans that will include uninsured children with affordable health care. Some restrictions apply. Please contact the school office for more information.)
Dentist: _____ Phone #: _____

How often does your child see a dentist?
Every six months: _____ Yearly: _____ As needed: _____
Does your child attend day care? Yes _____ No _____
Name of day care provider _____
Days and hours attending day care: _____

In case of emergency or illness and unable to reach parents, please call:
1. Name: _____ Relationship: _____ Phone #: _____
2. Name: _____ Relationship: _____ Phone #: _____

Does your child have allergies to: foods _____ medications _____
Other reaction _____ treatment _____

Does your child eat 3 meals a day? Yes _____ No _____
Any food intolerance or restrictions? Yes _____ No _____

Does your child have any special conditions? _____
Does your child take any medication? _____

Does your child have: Asthma _____ ADHD _____ Freq. ear infections _____ Heart disease _____
Freq. nose bleeds _____ Kidney disease _____ Freq. colds _____ Freq. headaches _____

Dizziness _____ Freq. sore or strep throat _____ Speech problems _____ Hearing problems _____
Vision problems _____ Diabetes _____

My child _____ has permission to take Tylenol: Yes _____ No _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

Parent signature: _____ Date: _____

Students may not participate in any after school activities until all their Back to School Forms are returned to the office.