Rising Tide Charter Public School Medical Information

(To be complete by parent or guardian)

Name of Child:_____ D.O.B.:_____

Name of Parent/Guardian:_____

Home Phone:_____ Cell:_____ Work:_____

Is the child covered by medical/hospital Insurance? ☐ Yes ☐ No

Cardholder's Name:_____ Plan Name _____Group No._____

Does the child have Dental Insurance? ☐ Yes ☐ No

Name of policy_____ Plan Name_____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communication will be confidential.

Immunization: Massachusetts law requires that all children enrolling in public school should be immunized. Your child's immunizations record will by photocopied and returned to you.

Child's pediatrician/physician:_____ Phone:_____

Child's Dentist: _____ Phone:_____ Date of Last Physical:_____

Is your child capable of participation in a full program of school activities, including recess and physical education? ☐ Yes ☐ No
(If no please explain:)_____

_____

Is your child taking any prescribed medications on a daily basis? ☐ Yes ☐ No
If Yes, please explain:_____

_____

Will your child be taking any medication at school ? ☐ Yes ☐ No
If yes please explain:_____

_____

List two emergency contacts other than parent/guardian who have your permission to pick up your child if you are unable to be reached

1._____ _____ _____ _____
Name Relationship Phone# Cell#

2._____ _____ _____ _____
Name Relationship Phone# Cell#

If I cannot be reached in the event of any emergency, I hereby grant permission to school authorities to secure and administer treatment for the above named person. This completed form may be photocopied for use on trips away from school. 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.

Signature of parent or guardian:_____ **Date:**_____

I give permission to the school nurse to give my son/daughter: Tylenol/Acetaminophen or Ibuprofen at a weight/age appropriate dosage for fever or headache
Parent or guardian signature_____Date_____

Please check all that apply to your child

☐ Heart Condition	☐ Diabetes	☐ Asthma	☐ Seizure Disorder (Date of last seizure)_____
☐ ADD/ADHD	☐ Migraines	☐ Depression	☐ Allergies(Specify)_____
☐ Hearing problems	☐ Left ear	☐ Right ear	☐ Hearing Aids
☐ Vision problems	☐ Wears glasses	☐ Contact lenses	☐ Protective Eye Wear

Was your child born prematurely? ☐ Yes ☐ No

Has your child ever had chicken pox? ☐ Yes ☐ No

Has your child ever been hospitalized ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child ever had surgery? ☐ Yes ☐ No If yes, please explain:

_____