



In order to enhance your child’s education and to insure safety, we are requesting information about your child’s general health and past medical history. The school nurse will communicate relevant health information to the appropriate school staff. **If you do not want this information shared with school staff, please notify the school nurse directly by calling (617) 354-0047 Ext 209 or emailing rferrara@ccscambridge.org**

Student Name _____ **Date of Birth** _____

Does your child have any of the following medical conditions?

	Yes	No		Yes	No
Orthopedic or Joint Problems			Cardiac Problems		
Seizures			Frequent Headaches		
Hearing Problems			Vision Problems (please circle all that apply) Glasses, contacts, reading, board work		
Asthma			Allergies (food or drug) Please list below:		
Diabetes			Other		

If **YES** to any of the above, please explain.

Please list **ANY** allergies

List **ANY** medication(s) your child is taking, including over-the counter drugs

Other condition(s) not listed



Occasionally a student will develop allergy symptoms, headaches, minor aches, or menstrual cramps during school hours that can interfere with learning. These symptoms may be relieved with an analgesic, antihistamine or anti-inflammatory medication. After careful assessment, the school nurse may administer only those over-the-counter medications approved by the school physician. **However, written consent is required before any medication is given to your child. In order to give your consent, you must complete the table below. This will be kept on file, secured in the office of the school nurse.**

I give permission for the school nurse to administer the following over-the-counter medication(s) to my child. Please check all that apply.

	Yes	No
Acetaminophen (i.e. Tylenol- 325-650mg)		
Diphenhydramine HCL (i.e. Benadryl 25mg)		
Ibuprofen (i.e. Advil - Motrin 400mg)		
Cough Drops ** - The parent/guardian must provide the cough drops. Please have your child bring the cough drops to the nurses office with their name on it and the nurse will administer them on an as needed basis.		

Parent/Guardian's Signature

Date

Parent Guardian Relationship to student _____ Best contact # _____

Emergency Contact #1 _____ Best contact # _____

Emergency Contact #2 _____ Best contact # _____

Student's Primary Care Provider _____ Phone # _____

Address _____ City _____

Health Insurance Carrier _____ Policy # _____