



**2 a. Has your child been diagnosed with any ALLERGIES?** [ ]Yes [ ]No **If yes, please specify:**

Food \_\_\_\_\_

Drug \_\_\_\_\_

Environmental \_\_\_\_\_

**2 b. Has your child ever had a life-threatening allergic reaction to any of the above?** [ ]Yes [ ]No

If Yes, you must provide the school nurse with a signed health provider's order and an EpiPen for school. Please contact the school nurse before your child starts school.

You may, but are not required, to answer the following questions regarding mental health:

**3 a. Has your child ever received services from a mental health provider?** [ ]Yes [ ]No **If yes, please provide:**

Name of agency \_\_\_\_\_ Phone \_\_\_\_\_

Name of counselor \_\_\_\_\_ Phone \_\_\_\_\_

Reason for services (Diagnosis, if known) \_\_\_\_\_

**3 b. Is your child presently in mental health services?** [ ]Yes [ ]No **If yes, please provide:**

Present diagnosis, if known \_\_\_\_\_

**3 c. Is your child currently on medication for a mental health issue?** [ ]Yes [ ]No **If yes, please provide:**

Name of medication \_\_\_\_\_

**3 d. Has your child ever been hospitalized for any mental health issues?** [ ]Yes [ ]No **If yes, please provide:**

Name of hospital, city, state \_\_\_\_\_ Date \_\_\_\_\_ Reason for hospitalization \_\_\_\_\_

**4. Please add any other information you would like to bring to the attention of the school nurse:**

\_\_\_\_\_

**5. Health insurance information:**

Child's Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Subscriber \_\_\_\_\_

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 your child's school nurse for information about these programs.

**6. A current physical exam and up-to-date immunizations are required to attend school, vacation academies and summer programs.** Send these documents to the attention of your child's school nurse.

**Please read and sign below:**

As the parent/guardian of the above named child, I acknowledge that in case of injury or illness, it is my responsibility to provide transportation from school to home or to a medical provider for my child. In case of a life-threatening, serious, or potentially disabling injury or illness, I, hereby, grant my permission for emergency transport of my child by ambulance or by school personnel as arranged by the school administration. I further grant permission for the administration of emergency medications by the school nurse to my child within the guidelines of the School Physician's Standing Orders. I give permission for the School Nurse to share information relevant to my child's health condition(s) with appropriate school personnel when needed to meet my child's health and safety needs. I further give permission to the School Nurse to exchange/release and receive medical information/medical records (including immunizations, physical exam copies, appointment times, health concerns) with/from my child's health care provider, mental health care provider, and all specialists, for the purpose of referral, diagnosis, and treatment.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (Printed) \_\_\_\_\_

*Thank you for completing this important form.  
Please contact me with your health-related questions. Sincerely, Your Child's School Nurse*