Hamilton-Wenham Regional School District

EMERGENCY MEDICAL CARD

* please use black ink to complete *

Student _____

Student ID _____ Gender _____

Homeroom: _____ Grade: _____

Thank you for completing this medical information section as thoroughly as possible. In the unlikely event that your child requires medical transport during school hours, this information could be vital to both the emergency transport and hospital team in caring for your child until you arrive. All medical information provided is maintained with the utmost confidentiality.

Student: _____ DOB Address: _____

Contact 1: _____ Home: Cell: _____ Work

Contact 2: _____ Home: Cell: _____ Work: _____

Contact 3: _____ Home: Cell: _____ Work: _____

Contact 4: _____ Home: Cell: _____ Work: _____

Physician: _____ Address: _____ Office Phone: _____

Do you have medical insurance? Yes ___ No ___ Company Name: _____ Policy # _____

* If you don't have insurance and would like information about obtaining coverage, contact your school's Health Office.

Does your child have any allergies (medication, food, environmental) that we should know about?

_____

Does your child have an Epi-Pen? Yes ___ No ___

Medications:

Please list any medications that your child takes on a daily, or as needed basis. Please include medication that your child takes either at school or outside of school hours, including doses and frequency. (For medications taken at school, you must complete the required forms, available from the Health Office and online.)

_____

_____

_____

Please circle any illness or condition your child has ever had, past or present:

ADD ADHD Anemia Anxiety/Depression Asthma Diabetes Eating Disorder Hypertension Tuberculosis ASD

Heart Disease/Surgery (please specify) _____ Kidney/Liver Disease (please specify) _____

Seizures (if yes, specify, ex. Childhood febrile, epileptic, etc.) _____

Behavioral Disorder (please specify) _____ Other: _____

Hearing and/or Vision Deficit _____

I hereby authorize the Hamilton-Wenham Regional School District, through its medical staff and/or local hospital, its physicians and staff, to act in the best interest of my son/daughter in the event of injury or need for immediate medical attention.

Signature of Parent/Guardian: _____ **Date** _____

TB RISK ASSESSMENT	**YES**	**NO**
Was the child born in Africa, Asia & Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or Middle East? In what country was the child born? _____		
Has the child lived or traveled in Africa, Asia & Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month?		
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?		
Have any members of the child's household come to the United States from another country?		
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?		

I request and authorize the School Nurse to administer Non-Aspirin for discomfort/fever to my child during the school year on an occasional basis. I release the school of responsibility for any ill effects resulting from the proper administration of this medication.

Yes _____ No _____

Signature of Parent/Guardian: _____ **Date** _____