SOUTHERN BERKSHIRE REGIONAL SCHOOL DISTRICT

STUDENT HEALTH & EMERGENCY FORM

(Please complete both sides)

RECORD # _____ **LASID** _____ **SASID** _____ **DATE FORM COMPLETED** _____

Town of Residence: (circle) Alford Egremont Monterey New Marlborough Sheffield School Choice State Ward Mt. Washington Tuition

School Name: _____ **Grade:** _____ **Teacher:** _____ **Bus #:**_____ **Date of Birth:** _____

Student's Name: _____ **Birthplace:**_____ **Gender: M F N**

Last First Middle (Circle One)

PLEASE INDICATE IF MOTHER OR FATHER SHOULD BE PRIMARY CONTACT FOR ILLNESS, ETC. ***MOTHER FATHER***

Mother/Guardian/Other 1 (Please circle one)

Name: _____

Parent 1 Home Phone #:_____

Parent 1 Cell Phone #:_____

Employer: _____

Work Address & Phone #:_____

_____

#1 email: _____

Mailing Address ***(Circle one)***

_____

Number Street Apt #

_____

Town State Zip Code

Residential Address (if different from above)

Street_____

Town/St/Zip_____

Father/Guardian/Other 2 (Please circle one)

Name: _____

Parent 2 Home Phone #:_____

Parent 2 Cell Phone #:_____

Employer: _____

Work Address & Phone #:_____

_____

#2 email:_____

Mailing Address

_____

Number Street Apt #

_____

Town State Zip Code

Residential Address (if different from above)

Street_____

Town/St/Zip_____

Only complete this section if applicable. Please place an 'X' for all that apply.

If parents are living apart, with whom does student live? ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

Who has legal custody? ☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

Name/s of Non-Custodial Parent/s: _____

Please provide a copy of any documented legal restrictions this individual has in relation to the student and/or student information (e.g., records, attendance, dismissal, restraining order, etc.).

***Please note: It is the responsibility of the custodial parent to provide supporting documentation (e.g., court orders, etc.) which verify this individual's limited access to the student and/or student information. If verifying documentation is not on file in the main office, the school is unable to restrict a parent/s rights to access student and/or student information.**

If I cannot be reached in the event of an emergency, the following **local** people may be contacted to assume responsibilities and provide transportation for my child.

Name: _____Phone:_____Relationship:_____

Name: _____Phone:_____Relationship:_____

Student's Siblings (if any)	Date of Birth	Grade	Name and Address of Last School Attended (if any)
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have health insurance? _____ Yes _____ No If yes, please list health insurance company & policy number:

_____

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

Child's Physician: _____ Phone Number: _____

Child's Dentist: _____ Phone Number: _____

List all medications that your child takes: _____

List any allergies or other conditions child may have: _____

_____

Circle any medical conditions that the school should be aware of, i.e.; Heart Condition, Diabetes, Asthma, Seizure Disorder, Migraines, ADD/ADHD, hearing or vision problems, eczema, history of anxiety/panic attacks or depressed moods, autism.

If your child has asthma please complete the following to allow us to better care for him/her.

Do you expect your child to need asthma medication at school? ____ Yes ____ No

Does your child's asthma interfere with his/her participation in sports or physical education class? ____Yes ____ No

(A separate physician's order form and parent consent form are required for medication to be administered at school. Forms may be obtained from the school nurse.)

This information is confidential, however, federal law permits the school health record to be shared with school officials on a 'need to know' basis and with very limited number of others, including those who could help in an emergency. In other circumstances my permission will be required. I give permission to exchange information with my child's healthcare provider.

ALL MEDICATION, INCLUDING INHALERS, MUST BE KEPT IN THE NURSE'S OFFICE UNLESS THERE IS A WRITTEN PHYSICIAN'S ORDER AND PARENT CONSENT FOR A STUDENT TO CARRY MEDICATION.

Provide any additional health information you believe will assist us in caring for your child:

_____

_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician/dentist above and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary, including transporting my child to an emergency care facility via ambulance if necessary.

Parent/Guardian Signature: _____ Date: _____