Student Name _____ Grade _____

MEDICAL INFORMATION FORM

There may be times when it is necessary to share this information with the school principal, your child's teacher or other members of the school staff. If there is any reason you would not want this information shared, contact the school. Vision, hearing and postural screenings mandated by the State will be performed in the appropriate grades throughout the school year. You will only be notified if your child does not pass the screening. Please feel free to call School Nurse Mary McNulty-Anglin at (617) 825-0703 ext 3271 if you have any questions regarding this form. Thanks for your continued support and cooperation!

If emergency medical attention is necessary and the school is unable to reach me, I authorize school staff to initiate medical treatment: (check one)

☐ Yes ☐ No

☐ **I have enclosed a copy of the student's health insurance card** (front and back)

Name of insurance company_____

Policy number _____ Policy Holder _____

Doctor's Name_____ Doctor's Phone _____

Preferred Hospital (family uses):_____

Dentist's Name _____ Dentist's Phone _____

☐ **I have enclosed a copy of a recent physical examination (less than one year old)** including all immunizations mandated by the state. (The state mandates 5 doses of DTaP, 4 doses of polio, 2 doses of MMR, 3 doses of Hepatitis B, 2 doses of varicella, and, for seventh grade only, Tdap. We also recommend an annual influenza vaccine.)

My child takes the following medication(s):

Name of Medication _____ Dose _____ Times _____

Name of Medication _____ Dose _____ Times _____

My child has the following medical conditions: (check any that apply)

☐ Food allergies (specify) _____

☐ Medicine allergies (specify) _____

☐ Vision Problems ☐ Wears Glasses

☐ Hearing Problems ☐ Wears Hearing Aid

My child has had surgery, illness, injuries, or other problems that the school should be aware of:

_____

_____

_____

_____ _____

Signature of Parent/Guardian **Date**