

**Boston Collegiate Charter School**  
**Health/Office Emergency Card for the 2019-2020 School Year**

*Please complete and return this form to the school nurse ASAP.*

**This form is double sided, please fill out both sides.**

**THIS INFORMATION IS IMPORTANT IN CASE OF ILLNESS, EMERGENCY,  
OR UNSCHEDULED DISMISSAL FROM SCHOOL.**

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Entering Grade \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Best Telephone \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Father's Name \_\_\_\_\_ Best Telephone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

**Best Contact during School hours:**

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship to student** \_\_\_\_\_

Primary language spoken at home:  English  Spanish  Other: \_\_\_\_\_

Is there any custody issues of which the school should be aware? If so, please explain.

\_\_\_\_\_

**In the event that a parent/guardian cannot be reached in an emergency or in the case of illness, please list two responsible adults to contact.**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Telephone \_\_\_\_\_

**If emergency medical attention is necessary and we cannot reach you, do you authorize school staff to initiate medical treatment? (Please check one)      Yes  No**

Hospital where you take your child if he/she is ill: \_\_\_\_\_

**Health Insurance Information:**

Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Telephone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Dentist's Telephone: \_\_\_\_\_

**'Over The Counter' Medication Administration Permission**

The school physician allows the school nurse to administer the Over the Counter (OTC) medications listed below. Any other medications require a physician's order.

**My child has permission to take the following OTC medications (please check):**

Acetaminophen (Tylenol)    Yes <input type="checkbox"/> No <input type="checkbox"/>	Allergy Relief (Benadryl)                      Yes <input type="checkbox"/> No <input type="checkbox"/>
Ibuprofen (Motrin/Advil)    Yes <input type="checkbox"/> No <input type="checkbox"/>	Antacid (Tums/Roloids)                         Yes <input type="checkbox"/> No <input type="checkbox"/>

**Please note:** The school nurse may use first aid treatments, including topical ones, to treat allergic rashes, insect bites, toothaches, minor-wound infections and minor burns unless otherwise indicated by parent/guardian.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(Please turn over to complete OTHER side)**

**Prescribed Medications:** Please list prescription and over the counter medications your child takes. Include herbal treatments.

Name of Medication & Dose	Reason	Home	School*

**\*Note: All prescription and some over-the-counter medications which your child must take at school require an MD/NP written prescription letter to keep on file at school. Please see attached form.**

**Health History: Life Threatening and Other Allergies**

Indicate if your child has a *physician verified* allergy. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the school nurse. *Written prescriptions are required for all Epi Pens, Benadryl and Inhalers.*

<input type="checkbox"/> Bee Stings	<input type="checkbox"/> Specific Food(s), specify:
<input type="checkbox"/> Peanuts	<input type="checkbox"/> Medication(s), specify:
<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Other, specify:
<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Seasonal/Environmental, specify:

Describe your child's allergic reaction symptoms: \_\_\_\_\_

Indicate treatment for allergic reaction at school: \_\_\_\_\_

**\*\*If your child has any life threatening allergies, please attach Emergency Care Plan.**

**Is Epi Pen required?**

Yes  No

Has Epi Pen ever been used?

Yes  No

Does your child carry his/her own Epi Pen?  Yes  No

**Is Benadryl required?**

Yes  No

Has Benadryl ever been used?  Yes  No

**Asthma inhaler (see form)**  Yes  No

**Illness/Chronic Conditions - Does your child currently have any of the following illnesses or conditions?**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Braces/ orthodontics	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> G6PD	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bone/Joint Problems	<input type="checkbox"/> Anemia
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Vision: Eyeglasses/ contact lenses
<input type="checkbox"/> Bowel Problems, Specify Below:	<input type="checkbox"/> Other Dental, Specify Below:	<input type="checkbox"/> Other, Specify Below:

**Please list any illnesses your child is being treated for:** \_\_\_\_\_

**Has your child had surgery or major injuries in the last year? Specify:** \_\_\_\_\_

**Does your child have any dietary or physical limitations:** \_\_\_\_\_

*(Please note that a note from your child's physician is required to excuse a child from school activity, including physical education, and for frequent restroom use.)*

**Is there any information about your child's physical or emotional status to help us make their education more productive?** \_\_\_\_\_

**Other Health Information:**

Please identify any other health concerns you have for your child that you would like the school nurse to be aware of. If you would like the school nurse to contact you to discuss your child's health concerns, please state so below:

**Confidential Information** I grant permission to the school nurse to share health information about my child, on a need to know basis, with his/her teachers and coaches. Yes  No

**Health Care Provider Release** I grant the school nurse permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time. Yes  No

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_