# NORTHBRIDGE PUBLIC SCHOOLS
# ANNUAL HEALTH INFORMATION FORM

Dear Parent/Guardian,
Please complete the information on **both sides of this form** and sign as requested. Return this form to the school with your child or by mail. It is important that the school have up-to-date information to meet the needs of your child in the event of an emergency. All information will be kept confidential according to Massachusetts State Law. If you have any questions, feel free to call the school office.

Student Name: _____ Grade: _____ Date: _____

**Permission for Over-the-Counter Medications (OTC)**

The following medications may be dispensed by the school nurse as needed only once during the school day. The school nurse will not be able to dispense these medications without your signature below.

| | | |
|---|---|---|
| Tylenol | □ YES | □ NO |
| Benadryl | □ YES | □ NO |
| 1% Hydrocortisone Cream | □ YES | □ NO |
| Triple Antibiotic Ointment | □ YES | □ NO |
| Caladryl | □ YES | □ NO |
| Orajel | □ YES | □ NO |
| Ibuprofen *(MS/HS only)* | □ YES | □ NO |
| TUMS *(MS/HS only)* | □ YES | □ NO |
| Hand Sanitizer (> or = to 60% alcohol) | □ YES | □ NO |

**Medications/Medical Conditions: Please list all medications that your child takes and any medical conditions that the nurse should be aware of, even if listed in previous years.**

Does your child use: An inhaler? □ YES □ NO An EpiPen? □ YES □ NO

If your child has been diagnosed by a licensed practitioner with a medical condition they may be eligible for a 504 evaluation. Please see your school nurse.

**Health Insurance/Provider Information**

Does your child have Health Insurance? □ YES □ NO

Health Insurance Company: _____ Policy Number: _____

Dentist's Name: _____

Doctor's Name: _____ Doctor's Phone Number: ( _____ ) _____ - _____

If you don't have health insurance, the Commonwealth of Massachusetts has health insurance plans that will provide uninsured children with affordable healthcare (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be kept strictly confidential.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

***(Complete Reverse Side)***

I, the undersigned, do hereby authorize the officials of Northbridge Public Schools to contact directly the persons named on the Student Biographical Information Verification Report as may be deemed necessary in an emergency, for the health of my child. In case of a medical emergency, the school will attempt to contact the parent/guardian before calling the student's primary care provider. My child may be transported by ambulance to a medical facility if necessary. I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment. I will not hold the school financially or legally responsible for the emergency care and/or transportation for said student.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE