

**Falmouth Public Schools**  
**Student Emergency/Medical Information**

**\*Please help us by completing both sides, signing both sides and returning this form to your child's teacher as soon as possible.**

Student Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Residential Address: \_\_\_\_\_ Gender: (Male/Female/Non-Binary): \_\_\_\_\_  
Non-binary: does not identify as just a male or female

Residential City/State/Zip: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing City/State/Zip: \_\_\_\_\_ AM Bus: \_\_\_\_\_ PM Bus: \_\_\_\_\_

**Please list all LEGAL Parents/Guardians:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Live with student \_\_\_\_\_ Non-custodial parent \_\_\_\_\_ Live with student \_\_\_\_\_ Non-custodial parent \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Place: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Email address: \_\_\_\_\_

Mailing address: \_\_\_\_\_ Mailing address: \_\_\_\_\_

**If parent/guardian is not available, or in case of emergency, I authorize the Falmouth Public Schools to contact and dismiss my child to:**

Emergency Contact Name	Phone #	Relationship
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

**Please list other children in the Falmouth Public Schools**

Name	School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Military Family Status-(Please circle only one if applicable)**

Is this student one of the following?

- 1.) A child of an active duty member of the uniformed services, National Guard and Reserve **on active duty orders**.
- 2.) A child of a member or veteran who is medically discharged or retired **for less than one year**.
- 3.) A child of a member who died **during active duty**.

**Signature of person completing form:** \_\_\_\_\_ **Date:** \_\_\_\_\_

☐ **ALERT:** Check here if there are any contact/dismissal restrictions and describe.

- 1) If this child resides with a legal guardian who is not the parent, a certified copy of the court order appointing the guardian must be attached.
- 2) If a custodial parent/guardian wishes the school to comply with provisions of a court order restricting access to the child, a certified copy of the court order must be attached.
- 3) If the student is an emancipated minor, a certified copy of the court order must be attached.

## STUDENT MEDICAL INFORMATION SHEET Grades 5-12

Student Name: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Dentist: \_\_\_\_\_

Private Health Insurance: Circle one YES NO TYPE/PLAN: \_\_\_\_\_

Are you on Mass Health? Circle one YES NO PLAN: \_\_\_\_\_

List All Medications: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Activity restrictions: \_\_\_\_\_

Any other pertinent information: \_\_\_\_\_

<b>Health Problems: check all that apply</b>		
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing aids/tubes
<input type="checkbox"/> Bowel/Stomach problems	<input type="checkbox"/> Depression	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Kidney/Urinary Disorder
<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Braces
<input type="checkbox"/> Allergies to medications	<input type="checkbox"/> Allergies (food, animal, environmental)	<input type="checkbox"/> Headaches: Migraines <input type="checkbox"/> Other
Other:		
<b>I give the School Nurse permission to administer: <input type="checkbox"/> acetaminophen or <input type="checkbox"/> ibuprofen to my child per label directions. Please check one or both.</b>		

My child has permission to use hand sanitizer under adult supervision during the school day.

Yes \_\_\_\_\_ No \_\_\_\_\_

If the Principal or Nurse believes my child is in need of prompt medical treatment, I authorize their transport to Falmouth Hospital. I give permission to the school nurse to share information relevant to my child's health 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please update the School Nurse if your child is hospitalized at any time during this school year or if there are changes in medical information.**