Douglas Public Schools Health Office

NURSE EMERGENCY FORM

STUDENT INFORMATION

First Name:________________________ Last Name:________________________

Grade:______ Birthdate:______________ Primary Language:______________

Home Address Street:____________________________ P.O. Box/Apartment #:____________

City:______________________ State:____________ Zip:____________

PARENT/GUARDIAN INFORMATION

Father:________________________ Phone:____________________

Mother:________________________ Phone:____________________

Guardian:________________________ Phone:____________________

If a parent/guardian cannot be reached please list emergency contacts who can be called to pick up your child:

Name:________________________ Phone:____________________

Relationship:____________________

Name:________________________ Phone:____________________

Relationship:____________________

MEDICAL INFORMATION

Student Physician:________________________ Phone:____________________

Student Dentist:________________________ Phone:____________________

Hospital Preference:________________________ Phone:____________________

(OVER)

First Name:________________________ Last Name:________________________

Grade:______ Birthdate:______________

Medical Condition Alerts and Their Treatments:

(i.e. allergies, seizure disorder, Diabetes, asthma, migraines, etc.)

1. Condition:____

   Treatment:____

2. Condition:____

   Treatment:____

3. Condition:____

   Treatment:____

Sharing Medical Information

- ☐ I give permission for 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 for the school nurse to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

Parent/Guardian Signature:________________________________ Date:__________

Permission for Over the Counter Medications

Please note that medications may be given only once during the school day. The school nurse may use first aid treatments including topical ointments like calamine lotion and hydrocortisone for allergic rashes and insect bites, Orajel for toothaches, antibiotic ointments to prevent possible wound infections, burn ointment for minor burns and cough drops for minor throat irritation. There will also be the usage of alcohol-based hand foam rub for students.

My child has permission to take the following medication:

(For grades PreK-5: the school nurse will contact a parent/guardian for permission prior to medicating their child)

- ☐ Tylenol (acetaminophen)
- ☐ Motrin (ibuprofen)
- ☐ Tums (antacids)
- ☐ Cough drops

Parent/Guardian Signature:________________________________ Date:__________

Douglas Public Schools Health Office

STUDENT HEALTH PROFILE

First Name:____________________ Last Name:____________________

Grade:______ Birthdate:____________

A. Has your child had any of the following diseases?

Chickenpox	Yes	No
Meningitis	Yes	No
Pneumonia	Yes	No

B. Does your child currently have any of the following?

ADD/ADHD	Yes	No
Anxiety	Yes	No
Asthma	Yes	No
Autism Spectrum Disorder	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Deafness	Yes	No
Fainting	Yes	No
Heart problems	Yes	No
Seizures	Yes	No
Migraine Headaches	Yes	No
Scoliosis	Yes	No
Vision impairment	Yes	No

C. Has your child had any operations?

Appendix	Yes	No
Hernia	Yes	No
Tonsil/Adenoids	Yes	No
Other	Yes	No

If yes, please specify:____________________

____

____

D. Has your child had any of the following?

Broken bone	Yes	No
Serious accident	Yes	No
Concussion	Yes	No

If yes, please specify:____________________

____

____

E. Has your child been hospitalized for any other reason?

Yes No

If yes, please specify:____________________

____

____

(OVER)

First Name:________________ Last Name:________________

Grade:________ Birthdate:________________

F. Does your child have any allergies?

Bee stings	Yes	No
Food	Yes	No
Insect bites	Yes	No
Medication	Yes	No
Seasonal allergies	Yes	No
Other	Yes	No

If yes, please specify:________________

G. Does your child require medication for an allergic reaction**?

Epi-pen	Yes	No
Benadryl	Yes	No
Other	Yes	No

If yes, please specify:________________

****If Yes to any of the above, a doctor's order is required to be turned in to the Health Office****

H. Does your child use any of the following?

Eyeglasses/contact lenses	Yes	No
Hearing aid	Yes	No
Wheelchair	Yes	No
Other	Yes	No

If yes, please specify:________________

I. Can your child participate in all school activities? Yes No

If no, please specify: ________________

J. Does your child take medication during the school day**? Yes No

If yes, please specify:________________

****If Yes to the above, a doctor's order is required to be turned in to the Health Office****

<u>PLEASE KEEP FOR YOUR RECORDS**</u>**

DOUGLAS PUBLIC SCHOOLS
SCHOOL HEALTH OFFICES

SCHOOL NURSES

Douglas Primary School
Jennifer Walker
Email: jwalker@douglasps.net
Phone: 508-476-2154, Fax: 508-476-4041

Douglas Elementary School
Melanie Brundage
Email: mbrundage@douglasps.net
Phone: 508-476-4200 (option 5), Fax: 508-476-2582

Douglas Middle School
School Nurse Leader
Kathleen Campbell
Email: kcampbell@douglasps.net
Phone: 508-476-3332 (option 5), Fax: 508-476-4036

Douglas High School
Melanie Gaucher
Email: mgaucher@douglasps.net
Phone: 508-476-4123, Fax: 508-476-7386

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