

ACADEMIC YEAR 2009-2010

GRADE \_\_\_\_\_ HOUSE \_\_\_\_\_

# LINCOLN SUDBURY REGIONAL HIGH SCHOOL STUDENT HEALTH AND EMERGENCY INFORMATION FORM

_____ (last) (first) (middle) <input type="checkbox"/> M <input type="checkbox"/> F STUDENT'S NAME	DATE OF BIRTH: _____ MM/DD/YEAR
_____ ADDRESS	

DOES YOUR CHILD HAVE HEALTH INSURANCE?  YES  NO

NAME OF INSURANCE COMPANY \_\_\_\_\_

POLICY # \_\_\_\_\_

*If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. (978-443-9961 Ext.2390) All communications will be kept confidential.*

DOCTOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

DENTIST: \_\_\_\_\_

PHONE: \_\_\_\_\_

*The information below may be shared with faculty on an as needed basis.* YES  NO

List any allergies: (insect bites, food, drug, environment) \_\_\_\_\_  
Type of reaction(s) \_\_\_\_\_

TREATMENT EPI -PEN  BENADRYL  OTHER  \_\_\_\_\_

LIST ANY OTHER HEALTH CONCERNS: (include chronic /serious illness, accident(s)/conditions-limiting participation educationally (and/or) athletically in school.)  
\_\_\_\_\_  
\_\_\_\_\_

LIST PRESCRIPTION MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### REQUIRES ANNUAL PARENT/GUARDIAN SIGNATURE

MEDICATION: I/WE give permission to administer over the counter medications as prescribed by the school physician.

TYLENOL  IBUPROFEN  TUMS  TOPICAL ANTIBIOTICS

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

(OVER) → → → → → → → →

## INTERVAL HEALTH HISTORY

Dear Parent or Guardian:

In order to keep your child's health record up to date and to provide better health services to your child, please complete the following health history and return it to your school nurse or house office. Please provide health information since the last school physical or school health history was completed.

Give dates, if possible, or attach a recent (within the past year) physical exam. If you have already submitted a physical exam for athletic participation, you DO NOT need to attach a copy to this form.

DATE OF LAST PHYSICAL EXAMINATION: \_\_\_\_\_ DATE OF LAST DENTAL EXAMINATION: \_\_\_\_\_

<input type="checkbox"/> ACCIDENTS	<input type="checkbox"/> CONVULSIONS OR SEIZURES	<input type="checkbox"/> HEART PROBLEMS/MURMURS
<input type="checkbox"/> ALLERGIC REACTIONS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> DENTAL PROBLEMS
<input type="checkbox"/> ASTHMA/OTHER RESPIRATORY INFECTIONS	<input type="checkbox"/> EAR INFECTIONS	<input type="checkbox"/> MENSTRUAL PROBLEMS
<input type="checkbox"/> SCOLIOSIS	<input type="checkbox"/> THROAT INFECTIONS	<input type="checkbox"/> HOSPITALIZATIONS
<input type="checkbox"/> BONE OR JOINT DISEASE	<input type="checkbox"/> FREQUENT HEADACHES	<input type="checkbox"/> RECEIVED RECENT IMMUNIZATIONS
<input type="checkbox"/> COMMUNICABLE DISEASES	<input type="checkbox"/> KIDNEY TROUBLE	TYPE: _____ GIVE DATES: _____ _____ _____ _____
<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> Since last school screening has had examination by Physician for: HEARING: _____ DATE: _____ VISION: _____ DATE: _____ POSTURAL SCREENING: _____ DATE: _____	<input type="checkbox"/> COMMUNICABLE DISEASE Please specify:

**Health Office:**  
 Jan Cavallo, RN  
 Joan Gaumnitz, RN  
 Gail Nozik, RN

**Please return promptly to:**  
 Lincoln-Sudbury Regional High School  
 390 Lincoln Road  
 Sudbury, MA 01776

Phone: 978-443-9961 ext. 2390  
 Fax: 978-369-3090

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