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. Thank you for your help.**

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, please contact the following in this order:

Emergency Contact Name	Phone #	Relationship
1) ______________________	________________	______________________
2) ______________________	________________	______________________
3) ______________________	________________	______________________

Please list other children in the Falmouth Public Schools

Name	School	Grade

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: ________________________________

Local Communities in Massachusetts have been approved to receive partial reimbursement from MassHealth for costs of certain health-related services provided by their school district, including, among others, hearing or eye tests, school physical, occupational and physical therapy services, and counseling services with the school social worker or psychologist.

With your permission (also known as consent), the school district will be able to seek partial reimbursement for services provided by MassHealth. If you have any questions regarding the MassHealth Reimbursement Program please call

Leanne Peterson at 508-548-0151 x 124

Signature: ____ Date: ____________________________________

List All Medications: ____

Date of last physical exam: ____

Activity restrictions: ____

____

Any other pertinent information: ____

____

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

If the Principal or Nurse believes my child is in need of prompt medical treatment, I authorize his/her 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.