

Complete Both Sides

Lynn Public Schools
Emergency/Medical Form
School Year 2024/2025

ID: _____

School: _____ Grade/Home Room: _____ Shop: (if Applicable) _____

General Information

Student: _____ Birth Date: _____ Birthplace: _____
Last First Middle

Address: _____ Phone #: _____
Street Address Apt# City State/ Zip Code

Male Female Language spoken at home: _____

Parent/Guardian

Name: _____
Last First Relationship

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Address if different from student: _____

Parent/Guardian

Name: _____
Last First Relationship

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____

Address if different from student: _____

Student Sibling(s)

Name: _____ School : _____ Name: _____ School: _____

Name: _____ School : _____ Name: _____ School: _____

IF YOU ARE UNAVAILABLE: Emergency Contacts /Permission to Dismiss (must be 18 or over)

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

Name: _____ Relationship: _____ Daytime phone#: _____

My Child May Not Be Dismissed To:

Name: _____ Relationship: _____

*Valid Restraining Order

Yes No

Name: _____ Relationship: _____

Yes No

(If yes, you must attach copy of order)

*****Parent /Guardian Signature: _____**

Complete Both Sides

STUDENT NAME: _____

HEALTH HISTORY

Do you have medical insurance?

Private Public (MA Health, Medicaid, Children’s Medical Security) No insurance

Name of Insurance Provider: _____

(Please contact the school nurse if you need assistance applying for medical insurance)

Medical Information

Please **CHECK ALL BOXES** that apply to your child. Contact the school nurse for additional confidential medical information.

ALLERGIES (food, insects, medications, environment) _____ **Epi-Pen?** YES NO

Asthma ADD / ADHD Autism Bleeding/clotting problems Depression

Diabetes Heart defect/disease Kidney Disease

OTHER _____

History of concussion with date(s) _____

Convulsions/seizures (date of last seizure): _____ Type of seizure disorder: _____

Operations or serious injuries (dates) _____

Special medical equipment required _____

Vision Problems (specify) _____ Wears eyeglasses? YES NO Wears contacts? YES NO

Hearing Problems (specify) _____ Left ear Right ear Hearing aid ? YES NO

Date of last physical exam: _____ **Restrictions (doctor’s note required):** _____

(Copy/proof of physical required prior to school entry and in grades K, 4, 7 and 10. Please send to school nurse.)

Medication(s) your child is currently receiving:

At home: _____

At school: _____

Student’s Doctor/Pediatrician

Dental Care Provider

Name _____ Phone Number _____

Name _____ Phone Number _____

DO NOT LEAVE BLANK:

PARENT AUTHORIZATION

- YES NO 1. I give permission for the school nurse to administer **Tylenol** to my child.
- YES NO 2. I give permission for the school nurse to administer **Ibuprofen** to my child. (age 12 and over)
- YES NO 3. I give permission for the school nurse to apply **Calamine** to my child for minor skin irritations.

*In the event that I cannot be reached in an emergency, I understand that my child will be transported to the hospital to receive medical attention.

*Please note that alcohol based sanitizer will be used at all schools. To opt out, please submit a letter to your school nurse.

*This health history is correct as far as I know, and my child has permission to participate in all activities except as noted by me.

*****Parent/Guardian’s Signature** _____ **Date** _____