

Lynn Public Schools

Welcome Center - 100 Bennett St. Lynn, MA 01905 - Telephone (781) 592-8796 – Fax (781) 598-3160

http://www.lynnschools.org/departments/welcome_center.shtml

Registration Form/Medical Form

General Information

School Year Current 2021 - Next School Year September 2021

Student: _____ Birth Date: _____
Last First Middle Month/Day/Year

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

Phone #: _____ Email address _____

Country of Birth _____ Gender: Male Female Non-binary

Is this student currently receiving accommodations on a 504 Plan? Yes No

Is this student receiving Special Education Services? (has an IEP?) Yes No

I believe that my family is currently homeless or in a homeless situation Yes No

Military Family Status Yes No If yes: Active duty members of the uniformed services, National Guard and Reserve on Active duty orders. DECEASED - Members who die on active duty. DISCHARGED

Parent/Guardian 1

Name: _____
Last First

Home Phone #: _____

Cell Phone #: _____

Email Address: _____

Address if different from student: _____

Relationship to student (please check one)

Mother Legal Guardian Foster Parent
 Father Custodial Guardian DCF / State Ward

Parent/Guardian 2

Name: _____
Last First

Home Phone #: _____

Cell Phone #: _____

Email Address: _____

Address if different from student: _____

Relationship to student (please check one)

Mother Legal Guardian Foster Parent
 Father Custodial Guardian DCF / State Ward

Student Sibling(s)

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#: _____

My Child May Not Be Dismissed To

Name: _____ Relationship: _____ YES NO

Name: _____ Relationship: _____ YES NO

*Valid Restraining Order

*(if yes, you must attach a copy of the order)

HEALTH HISTORY

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

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

Name of Insurance Provider: _____

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 _____

Previous School Name: _____ City _____ State _____

Phone Number: _____

DO NOT LEAVE BLANK: PARENT AUTHORIZATION

- YES** **NO** I give permission for the school nurse to administer **Tylenol** to my child.
 YES **NO** I give permission for the school nurse to administer **Ibuprofen** to my child. (age 12 and over)
 YES **NO** 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, and my child has permission to participate in all activities except as noted by me.

*****Parent/Guardian Signature**

_____/_____/_____
Date (month/day/year)