STUDENT MEDICAL FORM

Student's Name:	Gender: ____M ____F	DOB:
Grade:	Homeroom :	School Year:
Address:	Home Phone:	

Parent/Guardian Name		
Address		
Place of Business		
Phone Numbers	Home:	Cell:
	Business:	Other
Email		
Parent/Guardian Name		
Address		
Place of Business		
Phone Numbers	Home:	Cell:
	Business	Other
Email		

◊ Physician Name	Phone number ( )
◊ Dentist Name	Phone number ( )
◊ Does your child have Health Insurance? Yes No	Company

If you have no health insurance, MA has health insurance plans that provide uninsured children with affordable health care (restrictions may apply). Please contact the School Nurse for more information about these programs. ALL *communications will be confidential.*
In case of emergency, the school will attempt to contact parent/guardian before calling a student's primary care provider (Physician). Your child will be transported by ambulance to an emergency care facility if necessary.

◊ Name(s) of designated adult(s) who will assume responsibility and/or transportation if parent is unavailable.	
Name	Phone ( )
Name	Phone ( )
Name	Phone ( )
Please list medications child is presently taking at home as well as school:	

Please check all that apply:

( ) Allergies (Food, insects, medication, environmental)

( ) Heart Condition ( ) Diabetes ( ) Asthma ( ) Seizure disorder ( ) Scoliosis

( ) ADD/ADHD ( ) Migraines ( ) Depression ( ) Other (specify)

( ) Hearing problems Left ear Right ear Hearing aid(s) ( ) Ear Infections

( ) Vision problems Wears glasses Contact Lenses

( ) Needs preferential seating

List and describe any medical problems or changes during this past year (illness, surgeries, Fx, etc.)
and any overall health concerns:_____

Name/grade of sisters/brothers/ in Carlisle Public Schools:

_____/_____ _____/_____

_____/_____ _____/_____

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

Parent Signature _____ **Date**_____

Carlisle Public Schools

Student Name: _____

Permission to Dispense Tylenol

The Carlisle Public Schools has my permission to dispense an age-appropriate dose of Tylenol at the discretion of the school health personnel to:

Signature of Parent or Guardian_____

Print Name _____

Date _____

Permission to Dispense Ibuprofen

The Carlisle Public Schools has my permission to dispense an age-appropriate dose of Ibuprofen at the discretion of the school health personnel to:

Signature of Parent or Guardian _____

Print Name _____

Date _____

Please Note:

All other over-the-counter analgesics, anti-inflammatories, antihistamines, cough medicines, and other cold remedies must be supplied from home in the original bottle with a signed medical permission form from the parent/guardian.
Prescription medications must be in the original bottle with correct dispensing information on it, along with a Physicians note. Prescription medications to be given 10 days or less do not require a physicians note, but a note from parent with directions.
Medication forms are available in the health office.