SPRINGFIELD PUBLIC SCHOOLS
Care of Emergency Illness or Accident

Dear Parent/Guardian:

In order that we may care for your student in case of illness or accident in accordance with your wishes, please complete the information below and return this form to your school nurse.

Sincerely,

School Nurse

1. Name of Student_____Grade_____

School_____Birthdate_____

2. Address_____Phone #_____

Cell Phone # _____

3. Can parent/guardian be reached at work?_____

Employer_____ Phone # _____

4. Name of friend or relative who may be notified if unable to locate parent/guardian:

Name_____Address_____Phone #_____

I understand the school will try to contact the parent/guardian before calling the doctor. In the event that myself or above person cannot be located, permission is given to the school to call a doctor and/or take this student to an emergency hospital for treatment, by ambulance if necessary.

Insurance: HMO_____MASS HEALTH _____NONE_____
OTHER_____ Name of insurance_____

6. If serous illness or accident occurs at school, Please call this student's physician:

Dr._____ Phone #_____

7. In case of injury to teeth requiring emergency care, please call:

Dentist's Name_____ Phone #_____

I give my permission for the nurse to contact the above doctor or dentist for any health concerns about this student.

8. I will notify the school if there is a change in the above arrangements.

_____Relationship to student_____ Date_____
Signature of Parent/Guardian

Please also complete the Medical History Update Sheet on other side **FORM ER-1**

SPRINGFIELD PUBLIC SCHOOLS
MEDICAL HISTORY UPDATE INFORMATION SHEET

Name of Student_____

Has your child received a physical exam during the summer?
Yes___ No___. Date of last exam_____.
Has your child had any of the following medical problems within the last 12 months:

1. Been diagnosed as having a handicapped condition?	Yes____	No____
2. Been Hospitalized?	Yes____	No____
3. Received injuries requiring medical attention	Yes____	No____
4. Had an illness lasting more than one week?	Yes____	No____
5. Been taking medication regularly?	Yes____	No____
6. Does you child wear glasses or contact lenses?	Yes____	No____

Briefly explain any Yes answer to the above questions:_____

_____

_____

Any Recent Immunizations: check if received in the past year:
DTaP____ Polio___TdaP____Td___MMR____Hepatitis B___Varicella____Meningcoccal___

Does the student have any chronic health conditions? Please explain including any medication that is needed at school.
Asthma_____

Diabetes_____

Seizures_____

Behavior_____

Allergies_____

Restrictions for Physical Education_____

Any additional information the school should be aware of:_____

_____

I give permission to the school nurse, to share complete medical information with appropriate school personnel.

Signature of Parent/Guardian_____Date_____

FORM ER-2

Please also complete the Care of Emergency Illness or Accident Form on other side