Maurice J. Tobin K-8 School
Emergency information (for Nurse only)

Student Name: Date of Birth:

Address: ______________________________ Apt. # __________Zip code____________
Parent/Guardian Name: ____________________________ Cell phone # ___________________
Parent/Guardian Employer: __________________________ Work Tel.# ______________________
Parent email address: ______________________________

Emergency Contact- Name:__________________________ Phone # _______________________

Insurance Provider (BC/BS, MassHealth, Tufts, etc).: _________________________________
Policy Number: ____

Clinic or Doctor's Name: ______________________________ Tel. # _______________________

Does your child have any allergies? If so, please list: ________________________________
Does your child have an epi pen? Yes ___ No____
Has your child ever had a head injury? Yes __ No___ If yes, please explain__________________________
Does your child take medicine on a daily basis? Yes ____ No ___ If yes, please list medicine_____________
________________________________dose ______________ and time taken_______________________
Does your child have asthma? Yes ____ No_____
Does your child wear glasses or contacts? Yes ____ No_____
Any other past medical history____
____
I give permission for my child_________________________________ to receive the medications listed/**CHECKED** below as deemed necessary by the School Nurse. I understand that a generic equivalent medication may be used. I understand that **Only the School Nurse**, in accordance with established written protocols, will administer the medication(s) I have **CHECKED**. Please contact the School Nurse with any questions or concerns.

Please check ( )

( ) Ibuprofen (Advil, Motrin)
( ) Acetaminophen (Tylenol)
( ) Benadryl
( ) Bacitracin (or other antibacterial cream/ointment)
( ) Calamine Lotion/other topicals

__________________________________ ____________ ______________________________
Signature of Parent/Guardian Date Cell phone