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:

*Valid Restraining Order

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

(If yes, you must attach copy of order)

***Parent /Guardian Signature:_____

Complete Both Sides

**** PLEASE TURN OVER AND COMPLETE OTHER SIDE ****

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** _____