

**Brockton Public Schools  
Confidential Student Emergency Information Form**

Date \_\_\_\_\_

Student's Name \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_ Brockton, MA 0230 \_\_\_\_\_

Grade \_\_\_\_\_ Room \_\_\_\_\_  
 Birth Date \_\_\_\_\_  
 Place of Birth \_\_\_\_\_  
 Home Tel. ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_

Emergencies such as a sudden illness or accident often occur at school. In the event of an emergency, your child will be transported to the nearest local hospital.

**Please complete the following information:**

Parent 1/Guardian 1 Name \_\_\_\_\_ Address \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_ Relation to student \_\_\_\_\_

Parent 2/Guardian 2 Name \_\_\_\_\_ Address \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_ Relation to student \_\_\_\_\_

Child lives with Both ( ) Parent 1 ( ) Parent 2 ( ) Guardian ( )

Parent 1/Guardian's Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Address \_\_\_\_\_ City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Parent 2 /Guardian's Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_  
 Address \_\_\_\_\_ City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Please arrange for **two other** responsible adults to care for your child in the event that you cannot be reached.

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

**Please indicate if there are any family restrictions** (e.g., current restraining order)

**Please indicate if your child has had** Chicken pox \_\_\_ German measles \_\_\_ Tuberculosis \_\_\_  
 Please indicate if your child wears Hearing aid(s) \_\_\_ Glasses \_\_\_ Dentures or partial plates \_\_\_  
 List any **medications**, or **chronic health conditions** such as eye or ear problems, heart disease, diabetes, asthma, allergies\*, seizure disorder, etc. Explanation \_\_\_\_\_

**\*Indicate all allergies** (be specific) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel. ( ) \_\_\_\_\_  
 Dentist's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Health Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Group Number \_\_\_\_\_

Has your child had a physical exam within last two years \_\_\_ yes \_\_\_ no Date \_\_\_\_\_ Last dental visit Date \_\_\_\_\_

**I give permission for the School Nurse to share medical information with the appropriate school personnel and to contact my child's physician as necessary.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

List other children living in the home.

Name	Date of Birth	Name of School

If you have no health insurance, the Commonwealth of Massachusetts has a health insurance plan that will provide uninsured children with affordable health care (restrictions may apply). If you are interested in more information about this program, please contact the School Nurse.

The school nurse has a doctors standing orders from our school physician to administer Tylenol for pain, fever, Epipen for unknown anaphylaxis, Benadryl by mouth for itching, Hydrocortisone cream for inflammatory rashes, Antibiotic ointment for minor abrasions, and Albuterol nebulization for known asthmatics. I give permission to the school nurse to administer the medications listed above as ordered by the school physician.

Parent/ Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Copies:** Main Office (original) School Nurse (yellow) and Homeroom Teacher (pink)

Effective date 6/30/2015