Hadley Public Schools
Student Health Information Form

Last Name: _____ First: _____ DOB:_____Age:_____

Address _____ Home Phone: _____
Street Town

Parent/Guardian #1 _____Home Phone _____ Cell _____

Place of Employment _____ Work Hours _____ Phone _____

Parent/Guardian #2 _____Home Phone _____ Cell _____

Place of Employment _____Work Hours _____ Phone _____

Child Resides with _____

Emergency Contact (if parent/guardian cannot be reached):

1st _____ Relationship _____ Phone _____

2nd _____ Relationship _____ Phone _____

Child's Healthcare Provider_____ Phone _____

Child's Dentist _____ Phone _____

Child's Other Health Care Providers (including mental health and other specialty providers)
_____ Phone_____

Child's Health Insurance Provider: _____

ALLERGIES (including drug, food, environment) _____

Hadley Public Schools has standing orders for the following treatments/medications. Please indicate whether or not you give your permission for them to be administered to your child by the school nurse.

Acetaminophen	Yes / No	Ibuprofen	Yes / No
Aloe Vera	Yes / No	Moisturizing Lotion	Yes / No
Benedryl	Yes / No	Oral Anesthetic Ointment	Yes / No
Calamine Lotion	Yes / No	Petroleum Jelly	Yes / No
Cough drops	Yes / No	Saline Solution	Yes / No

I give permission for the school nurse and the above listed health care providers to communicate regarding pertinent health care information. Yes / No

I give permission to the school to treat and/or transport my child in the event of a serious illness or injury as appropriate if I am unable to be reached. Yes / No

I give permission for the school nurse to share my child's healthcare diagnosis and information relative to the prescribed treatment for his/her condition with appropriate school personnel. Yes / No

_____ _____
Parent Signature Date

OVER →

CONFIDENTIAL - Only seen by School Nurse
Please fill out as accurately as possible.

Medications taken by student on a regular basis including OTC and prescription:
(Please turn in medication forms if medication to be taken at school)

_____ _____
_____ _____

Health Conditions:
(Please check all that apply for your student)

ADD/ADHD
Asthma
- Rescue Inhaler
- Other Treatments:

_____

Allergies
- Explain: _____

_____
- EpiPen

Autism
Bleeding Problems
- Explain: _____

_____

Cancer
- Explain:_____

_____

Concussion / Head Injury
- List Dates:_____

Chronic or Recurring Condition
- Explain:_____

_____

Cystic Fibrosis
Depression
Diabetes
- Type 1
- Type 2
- Insulin Pump

Eating Disorder
- Explain: _____

_____

Emotional Issue
- Explain:_____

_____

Gastrointestinal Issue
- Celiac Disease
- Irritable Bowel Syndrome
- Crohn's Disease
- Other: _____

Hearing Impairment
- Left Ear
- Right Ear
- Devices:_____

Heart Condition
- Explain:_____

_____

Migraines
Mononucleosis (within past year)
Neurological Conditions:
- Spina Bifida
- Cerebral Palsy
- Seizure Disorder
- Neuromuscular Degenerative Disorder
- Other: _____

Orthodontics
- Explain: _____

_____

Orthopedic Issues
- Recent Fractures:_____

_____
- Recent Surgery: _____

_____
- Other: _____

Scoliosis
Skin Disorders /Conditions
- Explain: _____

_____

Surgery
- Explain: _____

_____

Vision Impairment
- Glasses
- Contacts

Other information:

_____
_____
_____
_____
_____

_____
Parent/Guardian Signature Date

*Please place updated form in an envelope addressed to the school nurse (for confidentiality) and return to your child's teacher as soon as possible. Thank you!