

# Lowell Public Schools

## EMERGENCY FORM

*Please Print:*

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender : M/ F Grade: \_\_\_\_\_

Address \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Home Phone# (978) \_\_\_\_\_

Mother's work # \_\_\_\_\_ Mother's Cell Phone# \_\_\_\_\_

Father's work # \_\_\_\_\_ Father's Cell Phone# \_\_\_\_\_

Student's Physician \_\_\_\_\_ Telephone # \_\_\_\_\_

**List 3 local adults (other than parent/guardian) who will assume immediate care of your child and pick up your child at school in the event of illness or emergency:**

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Name: \_\_\_\_\_ Tel: \_\_\_\_\_

Circle **all** current or active health conditions that apply to your child:

ADD ADHD Anxiety Asthma Autism/PDD Cerebral Palsy Depression Diabetes Heart Condition

Lactose Intolerance Migraines Seizure Disorder OTHER (please list)

Vision Problems (specify) glasses \_\_\_\_\_ contacts \_\_\_\_\_

Hearing Problems (specify) Left \_\_\_\_\_ Right \_\_\_\_\_ Hearing aids: Left \_\_\_\_\_ Right \_\_\_\_\_

Allergies (please list) \_\_\_\_\_

Is your child prescribed an **Epi pen** for treatment of the allergy listed above? Yes No

List medication and dosage taken by your child on a regular basis or as needed: \_\_\_\_\_

Does your child have health insurance? Yes No MassHealth? Yes No

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel as needed to meet my child's health and safety needs. Yes No

In case of emergency, your child will be transported to the hospital by EMS.

I hereby authorize the school nurse to contact my child's physician if necessary.

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