# Cardinal Spellman High School
# Medical Information Sheet



**Student**:

Name of Child:_____. Date of Birth:_____. Grade:_____.

Name of Parent/Guardian 1:_____.

Home:_____ Cell:_____Work:_____.

Name of Parent/Guardian 2:_____.

Home:_____ Cell:_____Work:_____.

**Emergency Contact:**

Name:_____Relationship:_____Phone:_____.

**Physicians**:

Child's Pediatrician/Physician:_____.

Phone:_____Date of Last Physical:_____.

Child's Dentist:_____.

_____Phone:_____Date of Last Cleaning:_____.

**Immunizations and Medications:**

**Massachusetts law requires that all children enrolling in school should be immunized- please provide a copy of your child's most recent physical and vaccine record.**

- Is your child capable of participation in a full program of school activities, such as physical education?
  - ❑ Yes
  - ❑ No. Please Explain_____.
- Is your child taking any prescribed medication(s) on a daily basis?
  - ❑ Yes. Please List Medication(s)_____.
  - ❑ No
- Will your child be taking any medications in school?**
  - ❑ Yes**Please List Medication(s)_____.
  - ❑ No

**If YES, please complete the Authorization for Prescription Medication Administration form and return with both Parent/Guardian and Licensed Prescriber signatures

If I cannot be reached in the case of an emergency, I hereby grant permission to the school authorities to secure and administer treatment for the above named person. This completed form may be photocopies for use on trips away from school. I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

**Signature of Parent/Guardian**_____. **Date**:_____.

**I give permission to the school nurse to give my son/daughter:**

- ❑ Oral Tylenol/Acetaminophen or Ibuprofen for fever or discomfort
- ❑ Oral Benadryl/diphenhydramine for non-life threatening allergic reactions
- ❑ Oral TUMS/calcium carbonate for indigestion
- ❑ Topical bacitracin for mild skin irritation
- ❑ Topical hydrocortisone cream for moderate skin irritation

*All above medications are dosed for appropriate age and weight and dispensed only after the assessment of the nurse.*

**Parent/Guardian Signature**_____. **Date**:_____.

| Health Concern | Circle one | If yes, please explain: |
|---|---|---|
| Does your child have any allergies (including to medicines, food, and/or any other substance) | Yes/No | |
| Does your child have asthma? | Yes/No | Does he/she need an inhaler? |
| Does your have diabetes? | Yes/No | |
| Does your child have seizures? | Yes/No | |
| Does your child have ADD/ADHD? | Yes/No | |
| Does your child have migraines? | Yes/No | |
| Does your child have a hearing problem or wear glasses/contacts? | Yes/No | Left, right or both ears? |
| Does your child have depression, anxiety, or any other mental health concern? (please specify) | Yes/No | |
| Does your child have a chronic illness? | Yes/No | |
| Has your child ever had a concussion? | Yes/No | Number of total concussions:<br>Date of last concussion:<br>Other relevant information: |
| Has your child ever had surgery? | Yes/No | |
| Has your child ever been hospitalized? | Yes/No | |
| Has your child ever had cancer? | Yes/No | |
| Has your child ever had COVID-19 or is vaccinated for COVID-19? | Yes/No | Date of COVID-19 Positive test:<br>Date and name of Vaccination(Please send copy of card): |
| **Girls only:** Does your child experience painful, irregular menstruation and/or is on medication | Yes/No | |
| Other health concerns? | Yes/No | |