Global Learning Charter Public School

STUDENT HEALTH INFORMATION FORM

Please complete the following information below and return to school immediately

Student's Name:____
Last Middle First

Grade: _________ Homeroom: _________________

Home Address: ____ Telephone: ___________________

Date of Birth: _________________________ Sex: _________ Primary Language: __________________

Does your child have health insurance: Yes ☐ No ☐ If yes, Company: _________________________

If you have no health insurance, Massachusetts has health insurance plans that provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse for more information about these programs. All communications will be confidential.

Mother/Guardian/Other: ____

Father/Guardian/Other: ____

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physican Name: ____ Phone: ____________________________

Dentist Name: ____ Phone: ____________________________

Please list all medications that your child takes: ____
____

A written order from a doctor AND parent is necessary if medication is to be taken in school. Aspirin and/or over-the-counter medication cannot be given unless these orders and medication are provided by the parent/guardian. Please contact your child's school nurse for the appropriate forms.

Please check all that applies to your child:

☐Heart Condition ☐Diabetes ☐Asthma ☐Seizure Disorder ☐ADD/ADHD ☐Migraines ☐Depression

☐Other (Specify) ____

☐Allergies (food, insects, medication, environment) Specify
____

☐Hearing problems (Specify) ☐Left ear ☐Right ear ☐Hearing Aids ☐Preferential Seating

☐Vision problems (Specify) ☐Wears eyeglasses ☐Contact Lenses ☐Preferential Seating

Can your child participate in our physical education program? ☐Yes ☐No If no, please explain:______________________
____

I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.

SIGNATURE:____DATE:______________________