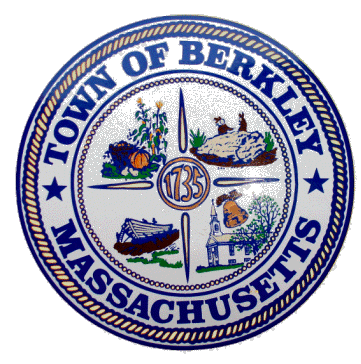
Somerset Berkley



Regional High School

“A Partnership for excellence”

Ms. Susan Brelsford Dr. Jahmal Mosley Mr. David J. Lanczycki

Assistant Principal Principal Assistant Principal

**MEDICAL INFORMATION FORM**

All information provided to the school nurse is confidential. It will be available to administration and nurses only, unless you request that specific information be given to your child’s teacher(s) for consideration in the classroom. Please return this form to the school nurse in a sealed envelope if it contains confidential medical information about your child.

STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE: \_\_\_\_\_\_\_\_\_\_

1. Does your child have any illness for which they are being treated? (i.e. diabetes, asthma, seizure disorder…) YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

Please give details. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Has your child ever had any surgery in the past? YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_
2. Has your child been treated for any psychological conditions within the past two years?

YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

Please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list any medication(s) your child takes on a regular basis:

Medication: Dose: Time of Day:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please indicate if your child is allergic to any of the following:
   1. Medication(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ c. Bee stings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Food(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ d. Environmental \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does your child have any restrictions that would interfere with his/her participation in physical education? YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

Please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note: If for any reason your child cannot participate in physical education, a doctor’s note or certificate is required **specifying the reason/diagnosis and duration of time** your child would be unable to participate in physical education classes.

1. Would you like your child’s teacher(s) to be notified of specific health/medical conditions or concerns that may impact your child’s performance in the classroom? YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

If YES, who would you like notified? (ALL TEACHERS\_\_\_\_\_) (JUST GYM TEACHER\_\_\_\_\_)

(OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Please be specific as to the information you would like released: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE: Please advise us of any concerns that may arise throughout the school year that have not been indicated on this form at this time.**

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

High School Address: Central Office Address:

270 Grandview Avenue 580 Whetstone Hill Road

Somerset, MA 02726 Somerset, MA 02726

508-324-3115 FAX: 508-324-3118 508-324-3100 FAX: 508-324-3104