Essex Agricultural and Technical High School
This Confidential Information Must Be Supplied by the First Week of School

Student's Name__________________________Grade/Div______Date of Birth_____________

Address____Tel:_______________________

Resides with: Both Parents Mother Father Other (Circle One Only)

Mother's Name__________________________Home Phone____________Work Phone__________

Father's Name__________________________ Home Phone____________Work Phone__________

Legal Guardian__________________________Home Phone____________Work Phone__________

In the event of sudden, serious illness or an accident requiring medical attention, and the parent cannot be reached, the student will be taken to the "Nearest Emergency Facility" (ambulance if necessary) and the parent will be responsible for all medical costs incurred. For this reason it is important to have emergency numbers where the school can reach the parents or their designate during school hours.

Persons to Notify in EMERGENCY if Parent/Guardian Cannot be Reached

Name__________________________________Relationship______________________________

Daytime Telephone__________________________________

Name__________________________________Relationship______________________________

Daytime Telephone____

Does Your Child Have Health Insurance? Yes/No (Circle One) Provider_______________________

Policy Number____________________________Name of Subscriber_______________________

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

Primary Doctor______________________Tel:_________________Last Physical______________

Dentist____________________________Tel:_________________Last Seen________________

If necessary, I give permission for the school nurse to give my child the following medication(s):

Benadryl Yes __ No __ Tylenol Yes ___ No ___ Rolaids Yes ___ No __ Ibuprofen Yes __ No ___
Cough Drops Yes ___ No ___ Buffered Aspirin Yes ___ No ___ Sudafed Yes ___ No ___

Please note any other medication that your child takes during the day, including dosages:

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Parent/Guardian Signature____Date_____________________

(OVER)

Allergies to Foods____________________ Special diet considerations:____________________
Medication allergies:____________________ Other serious allergies (i.e. bee sting)______________

Pertinent medical information to be completed by parent/guardian (check any/all that apply):

Asthma ___	ADD/ADHD ___	Heart Disease/Murmur ___
Ear Infections___	Kidney/Bladder Problems ___	Contacts/Glasses ___
Seizures ___	Nose Bleeds ___	Menstrual Problems ___
Migraines ___	Frequent Headaches ___	Recent Mononucleosis ___
Diabetes ___	Intestinal Problems ___	Dizziness/Fainting ___

Please explain any of the above items that were checked off:

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Any Special Health Conditions

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****Do you know of anything in the physical condition of this student that would tend to limit or prevent his/her participation in: (a) required training for physical or vocational education which will involve the use of hand tools, power equipment related to the curriculum? (b) interscholastic or intramural sports?**

If so, what____

Hospitalizations/Surgeries____

Injuries____

Name of Last School Attended____

Address of School____

I have reviewed the information on this form and believe it is accurate to the best of my knowledge.

Signature of Parent/Guardian Completing Form___________________________________

Date_____________________.