# Brockton Public Schools
# Confidential Student Emergency Information Form

Date______________________

Student's Name________________________________________________________
Last First Middle

Address__________________________________________ Brockton, MA 0230___

Grade_______ Room_____________
Birth Date________________________
Place of Birth______________________
Home Tel. ( ) ___________________
Cell Phone ( )__________________

Emergencies such as a sudden illness or accident often occur at school. In the event of an emergency, your child will be transported to the nearest local hospital.

**Please complete the following information:**

______________________________ ______________________________ _________________ ________
Mother's/Guardian's Name Address City/Town Zip

______________________________ ______________________________ _________________ ________
Father's/Guardian's Name Address City/Town Zip

Child lives with Both ( ) Father ( ) Mother ( ) Guardian ( )
Mother's/Guardian's Occupation ____________________ Place of Employment_____________________________________
Address__________________________________________ City/Town ___________________ Tel. ( ) _______________
Father's /Guardian's Occupation ____________________ Place of Employment_____________________________________
Address__________________________________________ City/Town ___________________ Tel. ( ) _______________

Please arrange for **two other** responsible adults to care for your child in the event that you cannot be reached.

Name____________________________________ Address_____________________________________________________
City/Town ________________________________ Tel. ( ) ________________

Name____________________________________ Address_____________________________________________________
City/Town ________________________________ Tel. ( ) ________________

**Please indicate if there are any parental restrictions** (e.g., current retraining order)

__________________________________________________________________________________________________

**Please indicate if your child has had** Chicken pox ___ German measles ___ Tuberculosis ___
Please indicate if your child wears Hearing aid(s) ___ Glasses ___ Dentures or partial plates ___
List any **medications**, or **chronic health conditions** such as eye or ear problems, heart disease, diabetes, asthma, allergies*, seizure disorder, etc.
Explanation _______________________________________________________________________________________
__________________________________________________________________________________________________

***Indicate all allergies** (be specific)

______________________________________________________________________________

Physician's Name_____________________ Address___________________________________ Tel. ( ) _____________
Dentist's Name______________________ Address___________________________________ Tel. ( ) _____________

Health Insurance__________________________________________________ Policy Number ___________________________
Group Number___________________________________

Has your child had a physical exam within last two years __ yes __no Date_______________________

Last dental visit Date_________________

**I give permission for the School Nurse to share medical information with the appropriate school personnel and to contact my child's physician as necessary.**

Signature of Parent/Guardian________________________________________________________ Date_________________

List other children living in the home.

| Name | Date of Birth | Name of School |
| --- | --- | --- |
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If you have no health insurance, the Commonwealth of Massachusetts has a health insurance plan that will provide uninsured children with affordable health care (restrictions may apply). If you are interested in more information about this program, please contact the School Nurse.

**Copies:** Main Office (original) School Nurse (yellow) and Homeroom Teacher (pink) Effective date 6/30/02