STUDENT HEALTH EMERGENCY INFORMATION CARD

School Year: _____

The Student Health Emergency Card contains valuable health information and provides important student contacts for use by the School Nurse in case of illness, injury or an emergency. ***Return the completed card to the school nurse.*** ***Additionally please notify the nurse of any changes in health information.***

Student Information			
	Last Name / First / Middle:		**DOB::**
	Address:		**Grade:**
	Mailing Address:		☐ **Male**
	City, State, Zip Code:		☐ **Female**
	Home Phone:	( )	With whom does the student live? ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Guardian**

Parent /Guardian Information		**Mother**	**Father**	**Guardian**
	Name:			
	Address			
	Work Phone:	( )	( )	( )
	Cell Phone:	( )	( )	( )

In case of emergency who is the primary contact? *(check one only)* ☐ **Mother** ☐ **Father** ☐ **Guardian**
Are there any dismissal restrictions? ☐ **NO** ☐ **YES,** _____

Emergency Contacts	***List two (2) individuals in Plymouth or the immediate surrounding towns who will assume temporary care of your child if you cannot be reached. Indicate their relationship to your child, such as aunt/uncle/neighbor/grandparent, etc.***			
	Name/ Relationship:		**Name/ Relationship**	
	Address:		**Address:**	
	Home Phone:	( )	**Home Phone:**	( )
	Cell/Work Phone:	( )	**Cell/Work Phone:**	( )

Please complete all sections, both sides

Current Health Information: *Please check all boxes that apply*			
	Is your child taking any ***regular*** medications? ☐ **YES** ☐ **NO**	*If yes, list the medications.*	
	Has your child had any illnesses, injuries and/or surgeries since last school year? ☐ **YES** ☐ **NO**	*If yes, please list.*	
	Diabetes: ☐ **YES** ☐ **NO** **Taking Insulin:** ☐ **YES** ☐ **NO**	**Severe Allergy:** ☐ **YES** ☐ **NO** *List allergies:* _____	**Asthma** ☐ **YES** ☐ **NO** **Uses Inhaler:** ☐ **YES** ☐ **NO**
	Heart Condition: ☐ **YES** ☐ **NO** *(If yes, describe)* _____		☐**Other Illness/Health Issues** *(List)* _____
	Hearing Problems: ☐ **YES** ☐ **NO**	☐ **Left Ear** ☐ **Right Ear**	**Hearing Aids:** ☐ **YES** ☐ **NO**
	Vision Problems: ☐ **YES** ☐ **NO**	☐ **Glasses** ☐ **Contacts**	**Other**

Physician		Dentist	
	Name: _____ **Phone:** ( ) _____ **Date of last physical exam:**		**Name:** _____ **Phone:** ( ) _____ **Date of last dental exam:**

STUDENT HEALTH EMERGENCY INFORMATION CARD
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Student Name: _____
Date of Birth:

PARENT/GUARDIAN CONSENTS FOR SCHOOL HEALTHCARE SERVICES

➢In the case of serious illness, injury or medical emergency, I request the school contact me. If the school is unable to contact me I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may take whatever actions deemed necessary relevant to my child's health and safety needs.

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

➢I give permission to the school nurse to share information relevant to my child's health condition with the appropriate school personnel when needed to meet my child's health and safety needs.

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

➢I give permission to the school nurse to exchange information with my child's primary care physician for the purposes of referral, diagnosis and treatment, and providing health records required for school attendance. This permission includes providing my child's most recent physical exam, pertinent office visit notes, lab results, and immunization record to the school nurse.

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

Print Name:

HEALTH and DENTAL INSURANCE INFORMATION: ***Please check all boxes that apply.***

The Commonwealth of Massachusetts now requires all residents to have health insurance. If you child is without health insurance or a health care provider (physician) please contact your school nurse for assistance. All communications are confidential.

Does your child have health insurance? ☐ **No** ☐ **Yes** ***(If yes, please provide health & dental insurance information below.)***

Private Insurance	Medicaid/MassHealth	Dental Insurance
Plan Name:	Plan Name:	Plan Name:
Subscriber ID #:	Subscriber ID#:	Subscriber ID #:
Policy/Plan #:	Policy/Plan #:	Policy/Plan #:
Student Insurance ID #:	Student Insurance ID #:	Student Insurance ID #:

AUTHORIZATION TO BILL MASSHEALTH FOR HEALTHCARE SERVICES:

I hereby give my consent to Plymouth Public Schools and/or its assignee to seek payment from MassHealth for health-related services provided to my child by the Plymouth Public School District.

Parent/Guardian Signature: **Date:**

RE: Payment from MassHealth for heath-related services
The Federal government has ruled that cities and towns may be reimbursed through the MassHealth program for the money spent for health related services in the school district. This means that a significant amount of funds can come back to our district – but we need your help. As you may know, it costs the school system a great deal of money to provide these necessary and important services.

The Plymouth Public School District is requesting the use of the Mass-Health number that may be assigned to your child. THIS WILL BE AT NO COST TO YOU. The Office of Medicaid has given written assurances to the State Department of Education that "the claim for Federal reimbursement under Medicaid for health-related services provided under Special Education Law 603 CMR 28.00 (formally Chapter 766) "will not result in any financial loss to a parent or child." In addition, no financial loss or reduction in available benefits will be experienced by a parent or child in any other program operated by Medicaid by reasons of their participation in "Municipal Medicaid Program."

You are not required to allow us to use your child's MassHealth number, but by agreeing to do so you are helping our district to be reimbursed for the cost of these vital services. This authorization is for reimbursement purposes only. Again, this will be at no cost to you. You may withdraw your consent at any time. Your child will still receive all services as needed in their educational plan and services provided by school health care services. Thank you for your support.

Signing the consent:
1. Will NOT affect ANY of your MassHealth benefits
2. Will only allow the school to receive reimbursement from the state government for some of the services the child receives at school
3. Will not release any medical records about your child
4. Will only release attendance information to enable reimbursement on a daily basis
5. Will not deter any services that your child receives
6. Will help your community with expenses it incurs
7. Will allow you to rescind your consent at any time

Not signing the consent:
1. Will not affect any services your child receives at the school
2. Will not bring any reimbursement into the community