British School of Boston

Student Health and Emergency Information Form 2014-2015

NORD ANGLIA EDUCATION

Student Data:

Last Name | First Name | Middle Name

Gender | Date of Birth | Year Group | Teacher

Residence Data:

Street

Apt. | City | State | Zip Code

Home Phone | Household Email

Contact Information (Parent/Guardian):

Parent/Guardian 1:

Name

Relationship | Street

Apt. | City | State | Zip Code

Home Phone | Mobile Phone | Pager/Other Phone

Email 1 | Email 2

Occupation | Employer

Employer Address

City | State | Zip Code | Work Phone

Parent/Guardian 2:

Name

Relationship | Street

Apt. | City | State | Zip Code

Home Phone | Mobile Phone | Pager/Other Phone

Email 1 | Email 2

Occupation | Employer

Employer Address

City | State | Zip Code | Work Phone

Emergency Contact Data (Other than Parents):

Contact 1:

Name

Relationship | Street

Apt. | City | State | Zip Code

Home Phone | Mobile Phone | Pager/Other Phone

Email 1 | Email 2

Contact 2:

Name

Relationship | Street

Apt. | City | State | Zip Code

Home Phone | Mobile Phone | Pager/Other Phone

Email 1 | Email 2

Call Priority: please prioritize names and numbers of individuals (listed above) in the order you wish us to call in an emergency:

	Name	Relationship	First Phone	Second Phone	Third Phone
Call 1st					
Call 2nd					
Call 3rd					
Call 4th					

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 Children's Hospital Boston if necessary.

Preferred Hospital _____ City _____ Phone _____

Medical Practitioner Data:

Primary Care Physician:

Name _____

Practice _____

Address _____

City _____ State _____ Zip Code _____

Phone 1 _____ Phone 2 _____ Fax _____

_____

Dentist:

Name _____

Practice _____

Address _____

City _____ State _____ Zip Code _____

Phone 1 _____ Phone 2 _____ Fax _____

_____

Student Health Data:

Health Insurance Provider _____ Policy Number _____

List All Allergies (food/med./insect/environ.): _____

List All Medications currently taken by child: _____

Check all that apply:

☐ Asthma	☐ Heart Condition: *(Specify)* _____
☐ Seizure Disorder	☐ Hearing Problems: *(Specify)* _____
☐ ADD/ADHD	☐ Vision Problems: ☐ *Glasses* ☐ *Corrective Lenses* *Other* _____
☐ Migraines	☐ Other: *(Specify)* _____
☐ Depression	

I give permission for the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

Signature _____ **Date** _____