Codman Academy Charter Public School, 637 Washington Street, Dorchester, MA 02124, 617-287-0700

STUDENT HEALTH FORM - 2021

1. **Student Name_____ Birth Date:_____**
2. **Grade_____**
3. **Name of Parent / Guardian _____**
4. **Phone:_____**
5. **Name of emergency contact _____ Phone: _____**
6. **Doctor's Clinic or Health Center_____**
7. **Phone_____**
8. **Dentist's Clinic (if one)_____**
9. **In Case of emergency transport my child to (Hospital)_____**
10. **Health Insurance Provider _____**
11. **Policy # _____**

Have you sent us the latest immunization/vaccination record for your child (for students of all ages)? You should be able to get the Immunization/vaccination record for your student from their doctor's office or clinic.

☐ **Yes**

☐ **No (if checked no, please provide a reason, school maybe able to provide assistance):**

_____

_____ _____

Parent/Guardian Signature **Date**

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Please check if your child has any of the following conditions:

☐ **Heart Condition**

☐ **Diabetes (If using insulin please provide a Diabetes Management Plan from your doctor)**

☐ **Asthma** ☐ **Needs Inhaler (Please provide an Asthma Action Plan and medication authorization form from your doctor)**

☐ **Seizure Disorder**

☐ **ADD/ADHD**

☐ **Migraines**

☐ **Depression**

☐ **Other _____**

☐ **Allergies** ☐ **Needs Epi-pen**

List allergies _____

(If your child has life threatening allergies, please provide an Allergy Action Plan and a signed medication authorization form from your doctor)

_____ _____

Parent/Guardian Signature **Date**

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AUTHORIZATION OF OVER THE COUNTER MEDICATIONS

I give my permission and request that designated school personnel administer the below over the counter medication as needed. (please mark)

( ) ACETAMENOPHEN/TYLENOL ( ) IBUPROFEN / MOTRIN ( ) ANTIHISTAMINE/ CLARITIN

_____ _____

Parent/Guardian Signature **Date**

If your child has an Epi-pen, inhaler, insulin, or will receive prescription medication at school please submit a Mediation Authorization from your physician.