Smith Vocational and Agricultural High School

80 Locust Street
Northampton, Massachusetts 01060

Student name:_____ Week attending:_____

Program:_____

Emergency/Health Form
Summer Youth Program

Dear Parent/Guardian and Student:

Please complete this Emergency/Health Form (both sides) and return it to the School Nurse. In case of a serious medical emergency, the school will make every attempt to contact the parent/guardian or other designate individual. If deemed necessary, your child will be transported by ambulance to an emergency care facility.

Student name: _____ Date of Birth: _____
Current Grade: _____Class: _____
Address: _____
Street Town Zip code
Home Phone: _____Cell Phone: _____

Parent/Guardian: _____
Address: _____
E-mail:_____
Home Phone: _____Cell Phone: _____
Place of Employment: _____
Work Phone: _____

Parent/Guardian: _____
Address: _____
E-mail:_____
Home Phone: _____Cell Phone: _____
Place of Employment: _____
Work Phone: _____

Other Emergency Contacts **(If a parent/guardian cannot be reached, the individual listed below can be contacted to assume responsibility and possible transportation of the student):**

1st Choice Name: _____Relationship:_____
Phone: _____ Cell Phone: _____Work Phone: _____

2nd Choice Name: _____Relationship:_____
Phone: _____ Cell Phone: _____Work Phone: _____

Does your child have Health Insurance: __ yes __ no
(If you do not have health insurance, the Commonwealth of Massachusetts has an affordable health insurance plan to provide coverage for uninsured families. Please contact the School Nurse for information.)

Health Insurance Provider: _____
Policy Number: _____

Doctor: _____Phone:_____

Dentist: _____Phone:_____

Does your student wear glasses or contacts? __Yes __No
Does your student have a hearing aid? __Yes __No

Health Conditions: _____
_____
_____
_____

Please list any medications, including inhalers, which your child takes daily:
_____
_____
_____

Allergies (please list):
Food: _____
Medication: _____
Other: _____
Does your child have an epi-pen? _____

__ Yes __No I give permission for the School Nurse to share information relevant to my child's health condition with appropriate school personal when needed to meet my child's health and safety needs while at the Summer Program.

__ Yes __No I give permission to the School Nurse exchange information with my child's Primary Care Provider for the purpose of referral, diagnosis, treatment, physical exam, and immunization status.

Date **Signature** **Relationship**