GEORGETOWN SCHOOL DISTRICT

Registration, Health, and Emergency Information Form

SCHOOL YEAR: _____

Student's Name _____ Grade: _____ Year of Graduation: _____
(Last) (First) (Full Middle Name)

Male: _____ Female: _____ Place of Birth _____ Date of Birth _____ Home Phone _____

Address _____ ***Check if new address:*** _____
(Street) *(Town)* *(Zip)*

Name and location of school last attended: _____ Grade: _____ Primary Language: _____

Optional – Ethnicity: Please check Hispanic or Non-Hispanic then choose appropriate selection on second line: ____Hispanic ____Non-Hispanic

___American Indian or Native American ___Asian or Pacific Islander ___Black ___White

LANGUAGE SPOKEN IN HOME: _____

Do you have any other students in the Georgetown School District: ____Yes ____No

Name/Grade: _____

Student residing with: Mother/Father _____ Mother only _____ Father only _____ Guardian _____

Mother/Guardian _____ Address (if different) _____

E-Mail Address: _____ Cell Phone: _____ Work # _____

Father/Guardian _____ Address (if different) _____

E-Mail Address: _____ Cell Phone: _____ Work # _____

EMERGENCY INFORMATION

Name of friends/relatives who will assume responsibility/transportation of your child if you cannot be reached:

Name _____ Relationship _____ Daytime Phone _____

Name _____ Relationship _____ Daytime Phone _____

The following information is requested for use in emergency situations only if parent/guardian cannot be located:

Physician Name _____ Phone _____

Dentist Name _____ Phone _____

SIGNATURE OF PARENTS OR GUARDIAN:

Mother/Guardian: _____

Father/Guardian: _____

Please list all medications that your child takes

_____

Please check all that apply to your child: ☐ Heart Condition ☐ Diabetes ☐ Asthma ☐ Seizure Disorder ☐ ADD/ADHD ☐ Migraines ☐ Depression
☐ Other (Specify) _____

☐ Allergies (food, insects, medications, environment)
(Specify) _____

Hearing Problems (Specify) _____ Left ear____ Right ear_____ Hearing Aide_____

Vision Problems (Specify) _____ Wears Eyeglasses_____ Contact Lenses_____

Does your child have health insurance? Yes____No____ Does your child have Dental Insurance? Yes____ No ____

Health Insurance Co. _____ Policy No. _____ Policyholder: _____

Dental Insurance Co. _____ Policy No. _____ Policyholder: _____

I give permission to 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 purpose of referral, diagnosis, and treatment.

I give permission for the school nurse to administer the age/weight appropriate dose of : ____Tylenol to my child.

Signature _____ *Date:* _____

If you have no health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the school nurse (978-352-5780 ext. 120) for more information about these programs. All communications will be confidential.