GEORGETOWN SCHOOL DISTRICT

Registration, Health and Emergency Information Form

SCHOOL YEAR: ____________

This form must be completely filled out, signed, and returned by the first day of school

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:______________________

Student residing with: Mother/Father_______ Mother only_______ Father only_______ Guardian______ ***Check if new phone numbers***: _______

Mother/Guardian____Address (if different)________________________________Phone:__________________

E-Mail Address:____Cell Phone: _______________________Work # ____________________________

Father/Guardian____Address (if different)________________________________Phone:__________________

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 (978-352-5790 ext. 520) for more information about these programs. All communications will be confidential.