TRI-COUNTY RVTHS SUMMER CAMP

STUDENT HEALTH / EMERGENCY INFORMATION

Complete the following information and bring to first day of camp.

Student's Name _____
Last *First* *Middle*

Address _____ City/Town _____

Home Phone _____ Date of Birth _____

Gender: _____ Female _____ Male

Does your child have health insurance? ____ Yes _____ No

Health Insurance Company _____

Policy Number _____

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 for more information about these programs. All communications will be confidential.

Mother/Guardian/Other _____ Home Address _____

Work Address _____

Phone: Home _____ Work _____ Page/Cell _____

Father/Guardian/Other _____ Home Address _____

Work Address _____

Phone: Home _____ Work _____ Page/Cell _____

Name of others who assume responsibility/transportation:

Name _____ Relationship _____ Day Phone _____

Name _____ Relationship _____ Day Phone _____

For minor injury/illness first aid will be provided according to school policy (standing orders). In case of emergency, the school will attempt to contact parent/guardian. Your child will be transported by ambulance to the nearest emergency care facility if necessary.

Physician Name _____ Phone _____

Dentist Name _____ Phone _____

Please list all medications that your child takes _____

Can your child participate in all school/camp activities? Yes _____ No _____ (explain on back)

Please check all that applies to your child:

___ Heart Condition ___ Diabetes ___ Asthma ___ Seizure Disorder ___ ADD ___ ADHD

___ Migraines ___ Depression Other (specify) _____

___ Serious Injuries (explain on back) Allergies _____

___ Hearing Problems (specify): Left Ear ____ Right Ear ____ Hearing Aids ____

___ Wears Glasses ____ Contact Lenses

I authorize Tri-County Regional School District to submit claims for health related services to MassHealth.

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 the purpose of referral, diagnosis and treatment.

Signature _____ Date _____