Framingham Public Schools

DEPARTMENT OF HEALTH AND WELLNESS
73 Mount Wayte Avenue, Suite 5, Framingham, MA. 01072
Telephone: 508-626-9197 Fax: 508-877-3243

Required Health Information

Below is the official health information required for every student entering grades 1 through 12 in Framingham Public Schools. To begin school, your child will need documentation of the following:

Physical Examination:

- ☐ A copy of your child's most recent physical examination (MUST BE within the last 12 months)

GRADES 1-6:

- ☐ DTaP/DTP (Diphtheria,Tetanus, Pertussis)/Td/Tdap – 3 to 5 doses depending on age and vaccination history
- ☐ Polio – 4 doses
- ☐ MMR (mumps, measles, rubella) - 2 doses
- ☐ HEPATITIS B – 3 doses
- ☐ Varicella (chicken pox) – 2 doses or physician documentation of history of chicken pox.
- ☐ Lead Test (under age 4: finger stick, over age 4 requires blood sample)
- ☐ TB Test Results (Tuberculosis) or Risk Assessment Form

GRADES 7-12:

- ☐ DTaP/DTP (Diphtheria,Tetanus, Pertussis)/TD/Tdap - 3 to 5 doses depending on age and vaccination history
- ☐ Tdap – 1 dose is required for entry to grades 7 – 12
- ☐ Polio – 3 or more doses
- ☐ Varicella (chicken pox) – 2 doses **or** physician documentation of history of chicken pox
- ☐ MMR (mumps, measles, rubella) - 2 doses
- ☐ HEPATITIS B - doses
- ☐ Tuberculosis (TB) test results or completed Risk Assessment

Complete the following forms:

- ☐ Emergency Information form
- ☐ Health History form

Once your child has been assigned to a school, please make an appointment to meet with the school nurse. Complete all forms. **Bring forms and immunization documentation to the appointment**. The nurse will review your child's health information. Your child can begin school as soon as all required health information is received. Thank you for your cooperation.

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Tuberculosis Risk Assessment

NAME_____DOB_____DATE_____

ADDRESS_____

Reason for TB screening/testing_____.

Was the child born outside the US? _____. Where_____.
Has the child been living outside the US? _____. How long? _____.

Has the child had a previous Tuberculin skin test?_____.
Where? _____When? _____Results? _____.

Has the child traveled outside the United States since being tested? _____ .

If so has the child been tested since returning to the USA?_____
Results _____.

Has the child lived or spent time with anyone who possibly or definitely had Tuberculosis?_____

Does anyone living in the household have a positive tuberculin skin test?_____

Did anyone living in the household come to the US from another country?_____

Has the child lived or spent any time with adults who:

- **Are homeless, living on the street or in a shelter?_____**
- **Have AIDS or are HIV infected?_____**
- **Used intravenous or street drugs?_____**
- **Lived in a correctional facility, nursing home or mental institution?_____**

Office use only.

Previous TB test result _____ Date_____ Done at _____.
Patient is _____is not_____ a candidate for a TB test.

_____RN

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OVER-THE-COUNTER MEDICATIONS (OTC)
PARENT PERMISSION FORM

The school physician for Framingham Public Schools, with the approval of the School Committee, and in compliance with Massachusetts Department of Public Health Regulations (105 CMR 210.00) has authorized the district's school nurses to administer the following over-the counter medications during the school day:

IBUPROFEN (Advil, Motrin)—for headaches, body aches or menstrual cramps
ACETAMINOPHEN (Tylenol)—for headaches, body aches or menstrual cramps
BENADRYL—for general allergy symptoms
TUMS/MAALOX—for upset stomach or indigestion
Visine Allergy Relief—for eye allergy symptoms

To assure safe administration of OTC medications to students during the school day, the school nurse will:

- Assess the student's condition, current medication profile, history of allergies and evaluate the need for medication.
- Review the signed parent permission form, which is valid for one school year.
- Call the parent/guardian to confirm, when necessary, the time of the last dose given.
- Administer the correct dosage according to the physician's written protocols.
- Document the medication administration in the health office visit log.
- Contact parent/guardians who have requested notification following OTC medication administration during the school day.

The Department of Health and Wellness will provide the over-the-counter medications listed below.

I give my consent to the school nurse to administer the following medications as needed during the school day.

Please Circle All That Apply:

IBUPROFEN ACETAMINOPHEN BENADRYL TUMS/MAALOX VISINE ALLERGY RELIEF

School_____
Student's Name**:** _____DOB_____
Parent's Signature**:** _____**Date:** _____
Parent's Phone Numbers:
(wk) _____(cell)_____(home)_____

Please notify me when OTC medication is administered to my child during the school day.
*Yes*_____ *No*_____
Comments: _____

FRAMINGHAM PUBLIC SCHOOLS
Department of Health and Wellness
Student Emergency Information

Student emergency contact information should be accurate and current. Please contact your school nurse with any changes.

Name of Student:_____School:_____Grade:_____

Home Address:_____Phone:_____

Birth date:_____Birthplace:_____

Parent's name:_____Address:_____ Phone:_____
Cell : _____
Employer:_____Phone:_____

Parent's name:_____Address:_____ Phone:_____
Cell:_____
Employer:_____Phone:_____

In an emergency, if parents cannot be reached, the school is authorized to contact:

Name:_____Address:_____ Phone :._____

Name: _____Address:_____ Phone:_____

If serious illness or accident occurs at school, please call my child's physician:

Dr:_____Phone:_____

In case of injury to teeth requiring emergency care, please call my child's dentist:

Dentist:_____Phone:_____

I give parental permission to share my child's health information with school personnel who need to know? ___Yes ___No

Do you have health insurance? ___Yes ___No

Insurance Company: _____

Are you in need of information about Massachusetts's health insurance plans? ___Yes ___No

If so, in what language _____? Do you need assistance in filling out the insurance forms? ___Yes ___No

In the event of an emergency situation where parents cannot be contacted, I authorize the school to obtain medical/emergency treatment for my child.

Additional comments/information:_____

_____

_____ _____
Signature of Parent/Guardian Date

STUDENT HEALTH PROFILE - HISTORY

PLEASE PRINT

_____
Last Name **First Name**

_____
Date of Birth

_____
Birthplace **Primary Language**

==========

Developmental History

Any difficulties with the pregnancy, labor or delivery with your Child? Yes___ No___ Please describe_____

_____

_____

_____

Was child born at full term? Yes_____ No_____
Was child born prematurely? Yes____ No_____
How many week s early or late was child born? _____
Was the child in good condition at birth? Yes___ No___
What difficulties did the child experience as a newborn?

_____

_____

At what age did your child achieve the following milestones:
Roll over ____ Sit unassisted_____ Crawl_____
Walk independently_____ Talk _____

ALLERGIES:

Does your child have any allergies (bee, insects, food, medicine, environment)? Yes_____ No_____ Describe:

_____

Are there any foods your child should not eat? Yes___ No___
What foods?_____

_____

MEDICATIONS:

Does your child take any medications or treatments on a regular Basis? Yes___ No___
Describe reason for medicine or treatment:_____

_____

_____

Medications	**Dose**	**Prescribing MD**

_____

HAS YOUR CHILD HAD	**Yes**	**No**	**Date**
Chicken Pox	____	____	____
German Measles	____	____	____
Measles	____	____	____
Mumps	____	____	____
Strep Infection	____	____	____
Pertussis	____	____	____
Polio	____	____	____
Diphtheria	____	____	____
Tuberculosis	____	____	____
Meningitis	____	____	____
Encephalitis	____	____	____
Pneumonia	____	____	____
Lyme Disease	____	____	____

Other:_____

_____

	Yes	**No**	**Date**
Anxiety Disorder	____	____	____
Asthma	____	____	____
Attention Deficit Disorder	____	____	____
Sleep Disorder	____	____	____
Vision Difficulties	____	____	____
Cerebral Palsy	____	____	____
Cystic Fibrosis	____	____	____
Hearing Problem	____	____	____
Diabetes	____	____	____
Encopresis	____	____	____
Eating Disorder	____	____	____
Epilepsy/seizures	____	____	____
Heart Problems	____	____	____
Kidney Disease	____	____	____
Mental Health Issues	____	____	____
Migraine Headache	____	____	____
Muscular Dystrophy	____	____	____
Tourettes Syndrome	____	____	____
Other chronic Health condition	____	____	____

Explain:_____

_____

_____

Has your child had any SURGERY: Please Describe:

_____

Type	**Hospital**	**Date**

_____

_____

DOES YOUR CHILD HAVE A DR's DIAGNOSIS FOR:

HAS YOUR CHILD ANY TROUBLE WITH:

	Yes	No
Vision:	____	____
Speech:	____	____
Hearing:	____	____
Ears: frequent infections /earaches	____	____
Frequent sore throat	____	____
Enlarged tonsils or adenoids	____	____
Frequent nosebleeds	____	____
Sinus infections	____	____
Dental issues	____	____
Being overweight	____	____
Being underweight	____	____
Being thirsty all the time	____	____
Frequent headaches	____	____
Dizziness or fainting spells	____	____
Temper outbursts	____	____
Mood Swings	____	____
Skin conditions	____	____
Chest pain	____	____
Heart murmur	____	____
Persistent cough or wheezing	____	____
Fatigue	____	____
Stomachaches	____	____
Chronic constipation	____	____
Chronic diarrhea	____	____
Frequent urination	____	____
Burning with urination	____	____
Painful, swollen, stiff joints	____	____
Walking or mobility	____	____
Numbness, tingling, weakness	____	____
Sleep	____	____
Drug, alcohol, or tobacco use	____	____
Risky behaviors	____	____

If yes, please describe and give M.D. name, if under care____
_____
_____

ACCIDENT/INJURY
TYPE OF INJURY HOSPITAL DATE
_____
_____

HOSPITALIZED FOR ANY OTHER CONDITIONS OR ILLNESS Yes___ No___

Problem Hospital Date
_____
_____
_____

MENSTRUATION:

HAS YOUR DAUGHTER STARTED HER PERIODS
Yes_____ No____
Age at first period_____
Describe any problems or concerns_____
_____

Does she take medication to relieve discomfort or irregularity?
Yes____ No___What medication?_____
_____

DOES YOUR CHILD USE ANY AIDS OR EQUIPMENT?

	YES	NO
Contact Lens	____	____
Eyeglasses	____	____
Hearing aid	____	____
Crutches	____	____
Braces for arm, leg or back	____	____
Wheelchair	____	____
Dental appliances or braces	____	____
Feeding tubes	____	____
Inhaler or nebulizer	____	____
Insulin pump	____	____
Oxygen	____	____
Catheter (urination)	____	____

Other, Please describe:_____
_____
_____

CAN YOUR CHILD PARTICIPATE IN ALL SCHOOL ACTIVITIES? Yes_____ No_____
If no, please explain:_____
_____
_____

DOES ANYONE IN CHILD'S IMMEDIATE FAMILY HAVE A HISTORY OF:

	Yes	No	Relationship
Asthma	____	____	_____
Tuberculosis	____	____	_____
Seizures	____	____	_____
Diabetes	____	____	_____
Heart disease	____	____	_____
Obesity	____	____	_____

Parent/Guardian Signature_____ Date_____