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

Kindergarten Registration
Required Health Information

Please bring the following information to your child's kindergarten registration appointment:

Physical Examination:

- ❑ A copy of your child's most recent physical (MUST BE within the last 12 months)
- ❑ Pre-school vision screening (from health care provider, MUST BE within the last 12 months)

Immunizations:

- ❑ 5 doses of DTaP
- ❑ 4 doses of Polio
- ❑ 3 doses of Hepatitis B
- ❑ 2 doses of MMR
- ❑ 2 doses of Varicella or physician documentation of history of chicken pox

Completed Health Forms:

- ❑ Emergency information form
- ❑ Health history form

Screenings:

- ❑ Lead Screening
- ❑ Tuberculosis (TB) test and results or completed Risk Assessment form

If your child is scheduled to have a physical/immunizations during the summer months, please request a copy from your doctor and send it to your child's school nurse before the start of school.

Thank you for your cooperation.

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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: ____

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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 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

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:_________________

Employer:____ Cell : _________________ Phone:_________________

Parent's name:______________________ Address:___________________ Phone:_________________

Employer:____ Cell:_________________ 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:____________________

DOES YOUR CHILD HAVE A DR's DIAGNOSIS FOR:

	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

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_________