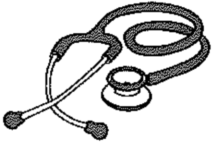
2021/2022



Petersham Center School
Office of the School Nurse

31 Spring St., PO Box 128
Petersham, MA 01366
Phone 978-724-3363 Fax 978-724-6687

Christine Warburton, RN
School Nurse
christine.warburton@petershamcenterschool.org

Date: ____________

Student name: ________________________________ **Date of Birth:** ______________ **Grade** _____

Dear parent/guardian,

Welcome to Petersham Center School! In order to provide proper care and comfort to your child please take a few moments to answer the following questions.

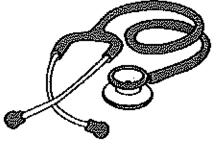
Allergies
Does your child have any allergies? ______ No ______ Yes If **YES**, please answer the following questions:
My child is allergic to: (i.e., food, medicine, animal, environmental) Please list below.

Allergy	Reaction
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please check if your child has any of these conditions:

- ☐ Asthma
- ☐ Attention Deficit Disorder (ADD)
- ☐ Attention Deficit Hyperactive Disorder (ADHD)
- ☐ Diabetes
- ☐ Eating Disorder or Weight Concerns
- ☐ Epilepsy or Seizure Disorder
- ☐ Frequent nosebleeds
- ☐ Glasses/contacts ☐ Full Time ☐ Part Time
- ☐ Other health conditions ________________________________
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hospitalizations ____________________
- ☐ Migraine Headaches
- ☐ Skin Problems
- ☐ Surgery ____________________

PLEASE COMPLETE REVERSE SIDE



Petersham Center School
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Does your child take any daily medications including over-the-counter medications? _________ No ______ Yes
If yes, please list:

Medication	Dosage	Frequency	Purpose

Does medication need to be given at school? ___ No ___Yes *If yes, please contact the school nurse so that the appropriate forms can be completed.*

Any other information that you feel would be helpful for the school nurse to know? (i.e., pertinent family medical history, family changes, prenatal/birth history, other)

____

____

Does your child wear/require any hearing assist devices? _______Please explain ______________________________

____

Does your child require any other assistive devices? ________
Please explain ____

____

<u>Parent Contact Information:</u>

Mother/Guardian: ________________________________ Home# ___________________________
Cell #________________________________ Work#___________________________

Father/Guardian: ________________________________ Home# ___________________________
Cell #________________________________ Work#___________________________
Emergency Person: ______________________________ Phone: ___________________________

New students must have a record on file of a physical exam done within the past year and proof of required immunizations. Please forward a copy or follow up with your primary care provider and forward the appropriate documentation.

***I give the school nurse permission to speak with my child's physician regarding the care of my child* □ Yes □ No**

Parent/guardian signature ________________________________ Date: _____________

If you have any health concerns, please feel free to contact my office at any time. Thank you for providing this very important information.

Christine Warburton, BSN, RN

Student Health Information Updated (7/2021)