Newburyport Public Schools
CONFIDENTIAL NEW STUDENT HEALTH INFORMATION

STUDENT: _____
Last Name First Name Middle Name Date of Birth Grade Entering

Primary Contact in the event of an emergency during school hours:

Contact #1: _____ Relationship:_____Phone: _____

Contact #2: _____ Relationship:_____Phone: _____

Health/Medical Conditions: Please check all that apply

ALLERGIES/INTOLERANCES **Life Threatening Allergies?** ☐ Bees ☐ Food (_____) ☐ Latex ☐ Medication (_____) **Epi-pen** ☐Yes ☐No **Food Intolerances** ☐ Lactose ☐ Gluten **Non-Life Threatening Allergies** ☐ Environmental Allergies ☐ Seasonal Allergies	**GASTRO-INTESTINAL** ☐**Constipation or Encopresis** ☐**Inflammatory Bowel Disease** ☐**Crohn's** ☐**Ulcerative Colitis** ☐**Irritable Bowel Syndrome (IBS)** ☐**Other GI**	**PSYCHO-SOCIAL/MENTAL/ BEHAVIORAL HEALTH** ☐ **Anxiety** ☐ **Depression** ☐ **PTSD/Trauma History** ☐ **Eating disorder** ☐ **Other**
NEUROLOGICAL ☐ **Epilepsy/Seizure disorder** ☐ Rescue medication for prolonged seizure? Med name: _____ ☐ Autism Spectrum Disorders ☐ **Migraine headache diagnosis** ☐ **Dizziness/Fainting** ☐ **Other**	**PULMONARY/RESPIRATORY** ☐ **Asthma (current)** **If yes, used asthma medication w/in past 2 years? ☐Yes ☐No** **Rescue inhaler ☐Yes ☐No** ☐ **Cystic Fibrosis** ☐ **Other Respiratory**	**ENDOCRINE** ☐ **Diabetes Type I** Insulin by ☐ Pump or ☐ Injection CGM ☐ Yes ☐ No CGM type: _____ ☐ **Diabetes Type II** ☐ **Other Endocrine**
BLOOD DYSCRASIAS ☐ **Anemia** ☐ **ITP** ☐ **Hemophilia** ☐ **Von Willebrand** ☐ **Sickle Cell Trait** ☐ **Other**	**DEVELOPMENTAL CONCERNS** ☐ **Communication** ☐ **Toileting** ☐ **Fine Motor** ☐ **Gross Motor** ☐ **Other**	**MUSCULO-SKELETAL DISORDERS** ☐ **Osgood Schlatters disease** ☐ **Arthritis** ☐ **Other**
MISCELLANEOUS ☐ **Vision concern** ☐ **Wears glasses/contacts** ☐ **Hearing impairment** ☐ **Ear Infection/Tubes** ☐ **Frequent nose bleeds** ☐ **Skin concerns**		☐ **OTHER PHYSICAL CONDITIONS**

Please provide additional details on health conditions that may require nursing services during the school day:

_____

☐ **Uses adaptive equipment:** hearing aids, sound field amplifiers, wheel chair, or crutches **(**list**)**

_____

☐ **Takes daily medication (list Name, Dose, Frequency):**

_____

Other information you would like to share about your child's health?

_____

Health Provider Information

	Last Name	First Name	Phone	None	Health Insurance ☐ Yes ☐ No
Physician	_____	_____	_____	☐	**Provider** _____
Dentist	_____	_____	_____	☐	**Policy #** _____

Permission

- Information on this form may be shared with appropriate school personnel in order to meet my child's safety and healthcare needs, and school nurse may communicate with medical provider for the purpose of diagnosis, treatment, and referral.

_____ _____ _____
Parent/Guardian Name **Parent/Guardian Signature** **Date**

Updated 1/13/2025