Montachusett Regional Vocational Technical School
MVP Student Emergency and Health Record
School Year 2025-2026

Name _____ School _____ Grade _____ Birthdate _____
Primary Language Spoken _____ Phone Number _____
Home Address _____
Parent/ Guardian Email _____

Mother/ Guardian _____ Home Phone _____
Home Address _____ Cell Phone _____
Work Phone _____

Father/ Guardian _____ Home Phone _____
Home Address _____ Cell Phone _____
Work Phone _____

- Are there any legal restrictions for the release of your child or his/ her records to the non-custodial parent?

___YES____NO If yes, please specify and provide legal documents: _____

List two people to whom we may release your child to assume temporary care of him/her if the school is unable to contact you.

1. Name _____ Relationship _____
   Home Phone # _____ Work Phone # _____ Cell Phone # _____
2. Name _____ Relationship _____
   Home Phone # _____ Work Phone # _____ Cell Phone # _____

List two people to whom we may release your child to assume temporary care for your child in the case of a disciplinary removal from school. If this information is the same as above, please write "same as above".

1. Name _____ Relationship _____
   Home Phone # _____ Work Phone # _____ Cell Phone # _____
2. Name _____ Relationship _____
   Home Phone # _____ Work Phone # _____ Cell Phone # _____

Physician Name _____ Telephone # _____
Does your child have health insurance? __Yes ___No Name _____ Policy # _____

Dentist Name _____ Telephone # _____
Does your child have health insurance? __Yes ___No Name _____ Policy # _____
Does your child see a dentist every 6 months? ___Yes ___No Fluoride treatment _____ Sealants _____

By signing below:

- I am authorizing the school to release my child to any of the people listed above
- I release all parties from all liability and responsibility while acting in the best interest of the above-named child.

*****Parent/ Guardian Signature:** _____ **Date:** _____

PLEASE NOTIFY THE SCHOOL OF ANY CHANGES AS SOON AS POSSIBLE

COMPLETE BOTH SIDES AND RETURN TO SCHOOL

HEALTH HISTORY; LIFE THREATENING ALLERGIES; MEDICATIONS

Please indicate if your child has a physician verified allergy to any of the following. If yes, please provide official documentation by your child's physician and an Emergency Care Plan to the Nurse's Office at the beginning of the school year. **Written MD orders are required for all EpiPens, Inhalers, Benadryl and prescription medications.**

ALLERGIES

Bee Stings____ Peanuts____ Nuts____ Medications _____ Other _____

Is an EpiPen Required? Yes____ No____ Is Benadryl Required? Yes____ No____

Has an EpiPen ever been used? Yes____ No____

Does your child carry their EpiPen? Yes____ No____

ILLNESS/CHRONIC CONDITIONS (Indicate if your child has experienced any of the following and explain)

Asthma	Anxiety	Attention-Deficit	Concussion
Depression	Diabetes	Fainting	Heart Condition
Hearing Deficit	Hospitalization	Lactose Intolerant	Migraines
Injuries	Scoliosis	Seizures	Migraines

Other: _____

Please explain condition: _____

_____

Vision: Eye Glasses/ Contacts Yes____ No____ Date of last eye exam: _____

MEDICATIONS (Please list prescribed and over the counter medications your child takes. Include herbal treatments.)

Name of Medication & Dose	Reason	Home	School

MEDICATION PERMISSION

****MUST CIRCLE YES OR NO****

Yes	No	I give permission to administer Acetaminophen 325-975 mg by mouth.
Yes	No	I give permission to administer Ibuprofen 200-800 mg by mouth.
Yes	No	I give permission to administer Tums (or generic equivalent) 1-4 tabs.
Yes	No	I give permission to administer Benadryl 25-50 mg by mouth.

*****Parent/ Guardian Signature:** _____ **Date:** _____

Our school physician, Dr. Lee Mancini, has agreed to grant his permission for the administration of Acetaminophen, Ibuprofen, Benadryl, and Tums in the school at the discretion of the School Nurse, with written parental permission. Please complete the above.

STATEMENT

"I hereby authorize the school to arrange transportation via ambulance to the hospital in the case of accident or serious illness. I understand that all attempts will be made to reach me. I give permission to the School Nurse to share information relevant to my child's health with the appropriate school personnel/bus driver when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician and specialists for the purpose of referral, diagnosis and treatment, as well as obtaining current immunization and physical exam status."

*****Parent/ Guardian Signature:** _____ **Date:** _____