**CHARMS Collaborative**

Old Colony YMCA, 445 Central Street• Stoughton, Massachusetts 02072

Tel. 781-344-1463 /fax 781-344-5299

EMERGENCY IDENITIFICATION AND CONTACT FORM 2016-2017

|  |  |
| --- | --- |
| Student Name |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth/Age |  | Health Ins & # |  |

|  |  |
| --- | --- |
| Home Address |  |

|  |  |
| --- | --- |
| Home Phone / Email |  |
| Parent/Guardian(s) |  |

 **Telephone contact numbers**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Father | Work # |  | Cell # |  |
| Mother | Work # |  | Cell # |  |

|  |  |  |
| --- | --- | --- |
| Current Medications and Dosages(Please list ALL medications, including OTC Medications) | Allergies(Please list both drug-related and food-related allergies) | Important Medical History/Information (please complete the other side of page also) |
|  |  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Emergency school contacts**

|  |  |
| --- | --- |
| Main Office | Charms Collaborative Tel 781-344-1463 |
| Executive Director | Rosalie O’Connell Tel 781- 364-4179 |
| Charms Nurse  | Lisa Coenen Tel. 781-774-9853 |
| **Emergency Contacts** | **Name** | **Address** | **Phone Number** |
| **Pediatrician** |  |  |  |
| **Specialist(s)** |  |  |  |
| **Friend/ Relative(s)** |  |  |  |
| **Friend/ Relative(s)** |  |  |  |
| **Guardian, Please sign here:** I consent for emergency services to be sought by Charms, to transport for medical treatment to the nearest hospital in the event that my child is considered to require emergency medical treatment. Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**STUDENT NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL MEDICAL INFORMATION AND COMMENTS**

Does your child have an Epi-Pen Yes No

 Has your child ever been stung by a bee or insect ? Yes No

 When ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What happened ? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods your child should not eat or is allergic to? Yes No What\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had an allergic reaction to any medication?

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any: Hospitalizations Yes No

Serious head injury Yes No

Please give dates/details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a history of: Asthma / Wheezing Yes No

Does your child have a rescue inhaler? Yes No

Seizure Disorder Yes No

 Last Seizure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other significant health information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_