HEALTH REGISTRATION FORM FOR NEW STUDENTS

Student's Name _____ Grade_____
Last First Middle

Home address _____ Phone_____
Street

_____
City State Zip Code

Birthdate_____/_____/_____ Birthplace_____ Sex: M____F___
Month Day Year City State/Country

PARENT/GUARDIAN

Name_____
Home Address_____
Home Phone Number_____
Present Occupation _____
Employer_____
Business Telephone_____
Car or cellular phone _____

PARENT/GUARDIAN

_____
_____
_____
_____
_____
_____
_____

With whom does your child live? (please check:)
Both parents ____ Mother ____ Father ____ Guardian ____ Stepparent____ Other _____

Physician_____ Phone_____ Hospital_____
Dentist_____ Phone_____ Date of last dental exam_____
Person to call if parent is unreachable:
Name_____ Phone_____

Please fill in the year your child had any disease or condition listed below:

Diseases
Chicken Pox _____
German Measles_____
Measles_____
Mumps_____
Rheumatic Fever_____
Scarlet Fever_____
Strep Throat _____
Tuberculosis (TB)_____
TB in Associates_____
Other_____

If yes to any answers in this section please explain on back of this page. The school nurse may wish to discuss this with you at a later date.

Conditions
Accident, Injury, Hospitalization_____
Attention Deficit Disorder_____
Allergy to *(list)*
Food _____
Insect _____
Medicine_____
Life-threatening_____
If yes, are medications needed for school?
Yes _____ No_____
Asthma_____
Arthritis_____
Autism_____
Asperger's_____
Behavioral Problem_____
Blood Disorder_____
Convulsions or Neurological Disorder__
Chronic Illness_____
Dental Problems_____
Diabetes_____
Ear Problems_____

Eye Problems:
Corrective Lenses
Are lenses impact-resistant?
When should glasses be worn?
☐ Boardwork ☐ Paperwork
☐ Phys Ed/Sports ☐ All the time
Loss of vision in one eye_____
Visually impaired_____
Hernia _____ Repaired _____
Heart Defect _____
High Blood Pressure
Language/Speech Disorder_____
Learning Disability _____
Loss/Impairment of one of paired organs:
(kidney, testicle)_____
Orthopedic Problems:
Scoliosis_____
Current Prescribed Medication:
Daily_____
As needed_____
Reason_____

Please note that for your child's protection, certain serious medical conditions, such as seizure disorder and severe allergies are made known in a confidential manner to appropriate faculty and staff members on a need to know basis. This will ensure that these individuals can properly respond in the event of a medical emergency. If you have any questions regarding this practice, please contact the school nurse in your child's school for more information.

Date of appointment for physical exam by own physician:

(over)

EMERGENCY MEDICAL CONDITION

Student Name: _____

My child has one of the following emergency medical conditions and will need an Emergency Care Plan completed by the school nurse and myself with written guidance from our private physician.

Please specify:

Asthma _____

Diabetes _____

Life-Threatening Allergy: food _____ insect_____ medicine_____

Poorly Controlled Seizures _____

Severe Swallowing Problems or Choking _____

Significant Heart Disease _____

Other _____

_____

_____

Additional Medical Information: _____

_____

_____

_____

_____

_____

_____

_____

Parent Signature _____ Date _____

Daytime Phone _____