

Must be completed and turned in at the time of registration.

School _____

REGISTRATION HEALTH INFORMATION

Student Name _____ Birth date _____ Grade _____

Parent Names _____

Phone (H) _____ (Cell) _____ (W) _____

*HEALTH HISTORY

Does the student have vision problems? ___ No ___ Yes ___ Mild ___ Severe ___ Contacts ___ Glasses

Does the student have a hearing problem? ___ No ___ Yes ___ Mild ___ Severe ___ Hearing Aid

Does the student have any of the following?

Allergies ___ No ___ Yes ___ Mild ___ Severe

If "yes", to what? _____

Describe allergic reaction: _____

How was reaction treated: _____

Asthma ___ No ___ Yes ___ Mild ___ Severe If "yes", complete the following:

Triggers: _____

Medications: _____ Inhaler at school? ___ No ___ Yes

Diabetes ___ No ___ Yes Type 1 ___ Type 2 _____

Heart Problems ___ No ___ Yes

Seizures ___ No ___ Yes

Describe: _____

Other issues (including learning disabilities, ADHD, behavioral issues) _____

****Does your child need medication while at school?** ___ No ___ Yes

If "yes", explain: _____

Does your child take medications at home? ___ No ___ Yes

If "yes", explain: _____

Will your child ride the school bus to and from school? No ___ Yes ___

*If the student has a medical condition such as allergies, severe asthma, diabetes, heart problems, seizures--- an individual student health plan will need to be completed each school year. This health plan will need to be shared with the student's teachers and other school staff for the safety of the student while at school.

**Students requiring medication (prescription and non-prescription) at school MUST have a written physician order and written parental consent. These forms are available in the school health office and on the school and district website. A new form must be completed each school year. Medications must be brought to the school health office by the parent/guardian—not the student.

Parent/Guardian Signature: _____ Date _____