

**PART I - HEALTH ASSESSMENT**

**To be completed by parent or guardian**

<b>Child's Name:</b>			<b>Birth date:</b>			<b>Sex</b>	
_____ Last                      First                      Middle			_____ Mo / Day / Yr			M <input type="checkbox"/> F <input type="checkbox"/>	
<b>Address:</b>							
_____ Number      Street		_____ Apt#      City		_____ State      Zip			
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>		<b>Phone Number(s)</b>			
				W: _____		C: _____	
				W: _____		C: _____	
<b>Your Child's Routine Medical Care Provider</b>				<b>Your Child's Routine Dental Care Provider</b>		<b>Last Time Child Seen for Physical Exam:</b>	
Name: _____				Name: _____		Dental Care: _____	
Address: _____				Address: _____		Any Specialist: _____	
Phone # _____				Phone _____			
<b>ASSESSMENT OF CHILD'S HEALTH</b> - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.							
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>				
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>					
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>					
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>					
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>					
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>					
Bladder	<input type="checkbox"/>	<input type="checkbox"/>					
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>					
Bowels	<input type="checkbox"/>	<input type="checkbox"/>					
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>					
Coughing	<input type="checkbox"/>	<input type="checkbox"/>					
Communication	<input type="checkbox"/>	<input type="checkbox"/>					
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>					
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>					
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>					
Feeding	<input type="checkbox"/>	<input type="checkbox"/>					
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>					
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>					
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>					
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>					
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>					
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>					
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>					
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>					
Seizures	<input type="checkbox"/>	<input type="checkbox"/>					
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>					
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>					
Surgery	<input type="checkbox"/>	<input type="checkbox"/>					
Other	<input type="checkbox"/>	<input type="checkbox"/>					
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____							
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Counseling etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____							
<b>Does your child require any special procedures?</b> (Urinary Catheterization, G-Tube feeding, Transfer, etc.) <input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____							
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.  <b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>							
Signature of Parent/Guardian _____						Date _____	

## NEW STUDENT HEALTH REGISTRATION

Dear Parent or Legal Guardian:

As your child is new to our school, completion of the following questionnaire will be helpful in assuring the best possible adjustment to our program. If a health problem is present, you can readily understand our desire to have this information as soon as possible. This information will be available to appropriate school personnel working with the students and the information will be kept in the student's health record.

Date \_\_\_\_\_

Name of Student \_\_\_\_\_ Entering Grade \_\_\_\_\_

Address \_\_\_\_\_ Birthdate \_\_\_\_\_

Previous school attended \_\_\_\_\_

Address \_\_\_\_\_

Name of Mother \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Name of Father \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Name of person to call in emergency \_\_\_\_\_ Phone \_\_\_\_\_

Has the student had any of the following health problems? (Check if yes).

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Convulsive Disorder | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Allergy        | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Speech Problem        |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> Hearing Problem       |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Severe Vision Problem |
| <input type="checkbox"/> Other _____    |  |  |

Is there a health problem that would prevent full participation in the school program or physical education program? \_\_\_\_\_

Is there a need for special seating? \_\_\_\_\_

Is the student on any long-term medication? \_\_\_\_\_

Is there a need for you or your child to have a conference with the nurse? \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian

*An Immunization Certificate Must Accompany This Form Prior To Entry To School.*