

HEALTH REGISTRATION FORM

**Schuylerville Central School
Elementary Building
(518) 695-3255 ext. 1220**

CHILD'S NAME _____ D.O.B. _____ SEX: M F GRADE _____

ADDRESS _____ PHONE # _____ BIRTHPLACE _____

FATHER'S NAME _____ EMPLOYER _____ PHONE _____

MOTHER'S NAME _____ EMPLOYER _____ PHONE _____

WITH WHOM DOES THE CHILD RESIDE _____

OTHERS LIVING AT HOME (FIRST AND LAST NAME):

SIBLINGS _____ D.O.B. _____ ADULTS _____ RELATIONSHIP _____

_____ D.O.B. _____

_____ D.O.B. _____

CHILD'S PHYSICIAN _____ PHONE # _____

****PLEASE ATTACH A COPY OF IMMUNIZATIONS****

PLEASE INDICATE IF YOUR CHILD HAS HAD THE FOLLOWING ILLNESSES OR CONDITIONS:

Anemia _____ Chicken Pox _____ Kidney Problems _____ Contact with TB _____

(Doctor Diagnosed)

Asthma _____ Pneumonia _____ Diabetes _____ Mumps _____

(Doctor Diagnosed)

Epilepsy _____ Heart Murmur _____ Rheumatic Fever _____ German Measles _____

(Doctor Diagnosed)

Tuberculosis _____ Heart Disease _____ Whooping Cough _____ Measles _____

(Doctor Diagnosed)

OTHER PREVENTIVE MEASURES (Dates of)

1. Is your child currently taking medication? YES _____ NO _____

What kind? _____ Dosage Required _____

For what reason? _____

2. Does your child have any allergies which require attention at school? YES _____ NO _____

Please list specific instructions for allergic reactions, especially bee stings: _____

***Please provide recommendations in writing from your physician for treatment of allergy**

Describe type of reaction _____

Name of Physician _____

Please Complete Both Sides

3. Have you ever suspected that your child may have a problem hearing? YES _____ NO _____
If so, has your child ever had their hearing testing? YES _____ NO _____
If so, what was the result of the examination and recommendations, if any? _____

Name of Physician _____

4. Have you ever suspected that he/she may have a vision problem? YES _____ NO _____
Has your child ever been seen by an optometrist or eye specialist? YES _____ NO _____
If so, what was the result of the exam and recommendation, if any _____

Name of Physician _____

5. Has your child had any other screening for medical evaluation? YES _____ NO _____
If yes, what were the results? _____

Name of Physician _____

6. Has your child been hospitalized at all since birth? YES _____ NO _____ DATE _____
If so, what was the reason? _____

Was your child born prematurely? YES _____ NO _____ How many Weeks premature? _____

7. During the past year, has your child had an illness, serious injury or operation? YES _____ NO _____
If yes, please describe it: _____

Is your child still under treatment? YES _____ NO _____

Name of Physician _____

8. Has your child ever seen a dentist? YES _____ NO _____ DATE _____
If so, for what reason? _____

9. Should your child be restricted from participating in school sports or gym? YES _____ NO _____
If yes, please provide recommendations from physician in writing.

10. Have there been any changes in your family during the past year such as:
Separation, divorce or remarriage? YES _____ NO _____
Death or serious illness? YES _____ NO _____
Or any other situation which may affect your child? YES _____ NO _____

If yes, please explain _____

11. Any additional information or comments you would like to share regarding your child _____

I understand that all reports and testing results will be treated confidentially.

Date

Parent Signature