



Health Registration Form

(Please be sure to complete all pages)

(518) 695-3255

Elementary Health Office: ext 1228 & 1229

Middle School Health Office: ext. 2293

High School Health Office: ext 2244

Student's Name: _____ Gender: M / F / NB Grade: _____

Address: _____ DOB: _____ Birthplace: _____

Father's Name: _____ Home Phone: _____ Cell: _____
Employer: _____ Employer Phone: _____

Mother's Name: _____ Home Phone: _____ Cell: _____
Employer: _____ Employer Phone: _____

With whom does the child reside? _____

Emergency Contact: _____ Phone: _____

Please indicate if your child has had any of the following illnesses or conditions.

Asthma _____	Concussion (Dates) _____	COVID (Dates) _____	Diabetes _____
Heart Disease* _____	Heart Murmur* _____	Kidney Problems _____	Physical Disability* _____
Seizure Disorder _____	Tuberculosis _____	Whooping Cough _____	Other* _____

*Please give further information: _____

Other Preventive Measures

1. Is your child currently taking medication? YES ___ NO ___
Name _____ 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 for
bee stings or food allergies:

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

Describe type of reaction_____

Name of Physician_____

3. Have you ever suspected that your child may have a problem hearing? YES____ NO____

If so, has your child ever had their hearing tested? YES____ NO____

If so, what was the result of the examination and recommendation, if
any?_____

Name of examiner_____

4. Have you ever suspected that your child 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 examination and recommendations, if
any?_____

Name of examiner_____

5. Has your child had any other screenings 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____
If so, what was the reason?_____

Was your child born prematurely? YES____ NO____

If so, 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 been seen by a dentist? YES____ NO____
If so, for what reason?_____ Date of visit_____

9. Should your child be restricted from participation in school sports or gym? If yes, please provide recommendations from a physician in writing. YES____ NO____

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. Is there a history of cardiac issues in the family? If so, please explain YES____ NO____

12. Any additional information or comments you would like to share regarding your child (resistance to eating certain items, toileting concerns, fears of any kind, etc.) _____

Please check one:

A current physical examination is required for all new entrants.

_____ A copy of a physical examination has recently been done by a physician licensed in New York State and a copy will be provided to the school health office.

_____ A physical examination has been scheduled with a physician in New York State. Date of physical:_____

Name and phone number of physician:_____

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

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

_____ I give permission for my child to be seen by the school physician, if needed.

DATE

Parent Signature