Health Registration Form

(Please be sure to complete all pages)

(518) 695-3255
Elementary Health Office: ext. 1228
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