# ELLINGTON PUBLIC SCHOOLS

Registration and Health Information Update Form

| STUDENT INFORMATION | | | |
|---|---|---|---|
| First: | Middle: | Last: | Grade: |
| Birth Date: / / | Nickname: | | |
| **Student address**: | | | P.O. Box: |
| City: | | State: CT | ZIP Code: |
| Home: ( ) - | | | Unlisted?: ☐Yes ☐No |

| PARENT/GUARDIAN(S) AT STUDENT ADDRESS | | | | |
|---|---|---|---|---|
| ☐ Mrs. ☐ Ms. ☐ Dr. | Name: | | | |
| Relationship: | | | Cell: ( ) - | |
| Employer: | | | Work: ( ) - | Ext: |
| Other: ( ) - | | Ext: | E-mail: | |
| ☐ Mr. ☐ Dr. | Name: | | | |
| Relationship: | | | Cell: ( ) - | |
| Employer: | | | Work: ( ) - | Ext: |
| Other: ( ) - | | Ext: | E-mail: | |
| **Custody Alert**: | | | | **Documentation must be provided** |

**PARENT NOT LIVING AT STUDENT ADDRESS**

Please include phone numbers only if intended for an additional emergency contact. Send school reports? ☐ Yes ☐ No

| | | | |
|---|---|---|---|
| ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | Name: | | |
| Relationship: ☐ Father ☐ Mother | Home: ( ) - | Cell: ( ) - | |
| Address: | | | P.O. Box: |
| City: | | State: | Zip Code: |
| Employer: | | Work: ( ) - | Ext: |
| Other: ( ) - | Ext: | E-mail: | |
| Stepparent: | Cell: ( ) - | Work: ( ) - | |

| ADDITIONAL EMERGENCY CONTACTS | | |
|---|---|---|
| Name: | | Relationship: |
| Home: ( ) - | Cell: ( ) - | Work: ( ) - |
| Name: | | Relationship: |
| Home: ( ) - | Cell: ( ) - | Work: ( ) - |

In case of emergency, calls are made in the order listed on this form starting with Home unless otherwise specified here. Call Order:

**SIBLINGS LIVING AT STUDENT ADDRESS**

| Sibling Name | Date of Birth | Sibling Name | Date of Birth |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

**SPECIAL TRANSPORTATION ISSUES**

Please provide details if the student is not taking their home bus in the morning or afternoon on a regular basis.

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**HEALTH UPDATE**

| Student Name: | |
|---|---|
| Student's Physician: | Phone: |
| Student's Dentist: | Phone: |
| Preferred Hospital: | |
| Does your child have any of the following allergies? | |
| Bee Sting: ☐Yes ☐No | Type of reaction: |
| | Treatment: |
| Food or Nut: ☐Yes ☐No | List: |
| | Type of reaction: |
| | Treatment: |
| Environmental: ☐Yes ☐No | List: |
| | Type of reaction: |
| | Treatment: |
| Other Allergies: ☐Yes ☐No | List: |
| Has your child had any illness, injury, or operation during the past year? | ☐ Yes ☐ No |
| (specify with dates) | |
| Does your child take any medications on a daily or regular basis? | ☐ Yes ☐ No |
| Please list: | |
| Vision: ☐ Glasses ☐ Distance ☐ Reading ☐ Worn constantly ☐ Contact Lenses | |
| Other Vision Problems: | |
| Hearing: ☐ Frequent Infections ☐ Tubes | ☐ Known hearing loss ☐ Right ☐ Left ☐Both |
| ☐ Hearing Aid ☐ Classroom FM System | |
| Are there any other issues the nurse should now be aware of? | ☐ Yes ☐ No |
| Please specify: | |

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary, including transportation to the hospital in case of emergency.

Signature of parent/guardian ____________________________________________Date ____________________