ELLINGTON PUBLIC SCHOOLS
Health Information for Registration

Student Name _____ Date of Birth _____ Entering Grade _____

Address _____ Phone_____

HAS THE CHILD EXPERIENCED ANY OF THE FOLLOWING: *(Please check and enter date of onset on line)*

□ Vision Difficulty _____ □ Glasses worn for distance ____ near ____ bifocals _____
amblyopia _____ surgery _____ contacts _____

□ Hearing Difficulty _____ □ Frequent ear infections _____ Fluid in ears _____
tubes in ears _____ are tubes still in place? _____
hearing aides _____ cochlear implants _____
classroom FM system _____

□ Speech Difficulty _____ □ Speech/Language Therapy _____

□ Asthma _____ □ Medication for asthma _____
Treatment for asthma _____

ALLERGIES: *(Please list only allergies diagnosed by a physician, not intolerances or sensitivities)*

Food (list) _____

Medication (list) _____

Seasonal (list) _____

Bee Sting - describe reaction _____
treatment _____

List any other medical conditions _____
_____

* List any medications the child is taking _____
Condition for which the medication is taken _____

** List any treatments/procedures the child needs done on a daily basis _____
_____

*** PLEASE NOTE: If medication is to be administered in school, see the nurse for forms.**

**** PLEASE NOTE: If required during school hours, see the nurse for forms.**

TYPE OF HEALTH PROBLEMS (List all that Apply)	YES	NO	AGE/DATE	DETAILS/COMMENTS
Anxiety/Depression				
Behavioral/Mental Health Issues				
Birth Problems/Premature Birth				
Blood Transfusions/Blood Disorders				
Cardiac Problems				
Chronic Constipation/Diarrhea				
Chronic Illness				
Convulsion/Seizure/Epilepsy				
Diabetes/Endocrine Disorders				
Eating Disorders				
Encopresis/Stool Retention/Soiling				
Enuresis (bed wetting)				
Fractures (broken bones)				
Gastrointestinal (stomach)				
Headache/Migraine				
Hospitalizations/Surgeries				
Physical Limitations/Disabilities				
Scoliosis				
Serious Injury/Accident				
Skin Problems/Rash/Eczema/ Severe Acne				
Tics/Tremors				

List any significant family medical history _____
_____
_____

Additional Comments/Concerns
_____
_____

Student lives with both parents _____ Mother _____ Father _____ Other _____

Mother's/Guardian Name _____

Home No. _____ Work No. _____x____ Cellular _____

Father's/Guardian Name _____

Home No. _____ Work No. _____x____ Cellular _____

Emergency contacts when parents cannot be reached:

1. Name _____ Relationship _____
   Home Telephone _____ Work Telephone _____x___

2. Name _____ Relationship _____
   Home Telephone _____ Work Telephone _____x____

Student's Physician _____ _____
Name *Phone*

Student's Dentist _____ _____
Name *Phone*

Signature of Parent/Guardian _____ _____
Date

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 _____