

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 _____ Parent 1 _____ Parent 2 _____ Other _____

Parent/Guardian 1 Name _____

Home No. _____ Work No. _____ x _____ Cellular _____

Parent/Guardian 2 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*** _____