



Academic Year 2010-2011
HEALTH REGISTRATION FORM
{Both parents must sign the back of this form}

Student's Full Name: \_\_\_\_\_ Male { } Female { }
Date of Birth: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_
Contact Phone # \_\_\_\_\_

MEDICAL

Name of Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_
Name & Address of Medical Facility: \_\_\_\_\_
Medical Record Number \_\_\_\_\_ Date of last check-up: \_\_\_\_\_

DENTAL

Name of child's dentist: \_\_\_\_\_ Phone # \_\_\_\_\_
Address: \_\_\_\_\_
Date of last exam: \_\_\_\_\_

HEARING/VISION

Does your child have hearing loss? Yes \_\_\_ No \_\_\_ Are hearing aides required? Yes \_\_\_ No \_\_\_
Does your child have vision loss? Yes \_\_\_ No \_\_\_ Are glasses or contacts required? Yes \_\_\_ No \_\_\_
Remarks \_\_\_\_\_

SPEECH/LANGUAGE

Is English your primary language? Yes \_\_\_ No \_\_\_ If not, what is? \_\_\_\_\_
Do others have difficulty understanding your child? Yes \_\_\_ No \_\_\_
Remarks \_\_\_\_\_

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has:
\_\_\_ Asthma \_\_\_ Bleeding disorder \_\_\_ ADD/ADHD \_\_\_ Learning disability
\_\_\_ Diabetes \_\_\_ Bone/muscle disease \_\_\_ Skin condition \_\_\_ Seizure disorder
\_\_\_ Heart condition \_\_\_ Mental health condition
(i.e. depression, anxiety, eating disorder)

Other \_\_\_\_\_

Does your child experience any of the following?

\_\_\_ Nose bleeds \_\_\_ Frequent ear aches \_\_\_ Overweight for age \_\_\_ Physical disability
\_\_\_ Poor appetite \_\_\_ Frequent stomach aches \_\_\_ Frequent headaches \_\_\_ Fainting spells
\_\_\_ Tires easily \_\_\_ Emotional concerns \_\_\_ Underweight for age

Other \_\_\_\_\_

Do any of the above condition(s) limit/effect your child at school? Yes \_\_\_ No \_\_\_

ALLERGIES

\_\_\_ Plants \_\_\_ Animals \_\_\_ Food \* (see back) \_\_\_ Molds \_\_\_ Drugs \_\_\_ Bees

Other \_\_\_\_\_

LIFE-THREATENING CONDITIONS

Does your child have a life-threatening health condition? Yes \_\_\_ No \_\_\_

Describe: \_\_\_\_\_

MEDICATION

Does your child take any medications? Yes \_\_\_ No \_\_\_ If yes, name medication \_\_\_\_\_
Purpose: \_\_\_\_\_ Will medication be needed at school? Yes \_\_\_ No \_\_\_

**\*FOOD ALLERGY ASSESSMENT FORM**

Doctor treating food allergy: \_\_\_\_\_ Phone: \_\_\_\_\_ Facility: \_\_\_\_\_

Do **you think** your child's food allergy may be **life-threatening**? Yes \_\_\_ No \_\_\_

Did your child's **doctor tell you** the food allergy may be **life-threatening**? Yes \_\_\_ No \_\_\_

Has your child's **doctor** required an **allergy free environment** at home Yes \_\_\_ No \_\_\_ and/or in the classroom?  
Yes \_\_\_ No \_\_\_ If your doctor is requiring an allergy free classroom, his/her letter must be attached.

**If your child has a life-threatening food allergy, parents must provide snack for their children to keep in their classroom.**

**HISTORY and CURRENT STATUS**

Check the foods that have caused an allergic reaction:

\_\_\_ Peanuts/Peanut butter/Peanut oil      \_\_\_ Tree Nuts (walnuts, almonds, pecans, etc.)  
\_\_\_ Fish/shellfish      \_\_\_ Eggs      \_\_\_ Milk/dairy      \_\_\_ Soy products

Please list any others: \_\_\_\_\_

How many times has your student had a reaction? Never \_\_\_ Once \_\_\_ More than once \_\_\_

Explain: \_\_\_\_\_

When was the last reaction? \_\_\_\_\_

Are the food allergy reactions: Staying the same \_\_\_ Getting worse \_\_\_ Getting better \_\_\_

**TRIGGERS AND SYMPTOMS**

What has to happen for your student to react to the problem food(s)? (Check all that apply)

\_\_\_ Eating foods    \_\_\_ Touching foods    \_\_\_ Smelling foods

\_\_\_ Other, please explain: \_\_\_\_\_

Is it possible for other classroom students to have the identified products in their lunch/snack as long as they sit at a different table? Yes \_\_\_ No \_\_\_ (If No, a letter from your doctor must be attached.)

What are the signs and symptoms of your child's allergic reaction? (Be specific; include things the student might say.)

\_\_\_\_\_

How quickly do the signs and symptoms appear after exposure to the food(s)?

Seconds \_\_\_ Minutes \_\_\_ Hours \_\_\_ Days \_\_\_

**TREATMENT**

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

Yes \_\_\_ No \_\_\_ Explain: \_\_\_\_\_

Does your student understand how to avoid foods that cause allergic reactions? Yes \_\_\_ No \_\_\_

What treatment or medication has your Health Care Provider recommended for use in an allergic reaction?

\_\_\_\_\_

\_\_\_\_\_

Have you used the treatment? Yes \_\_\_ No \_\_\_

Does your child know how to use the treatment? Yes \_\_\_ No \_\_\_ Describe any side effects or problems your child had in using the suggested treatment: \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

*I understand that the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered. **BOTH PARENTS MUST SIGN THIS FORM.***

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_