Student Health Registration Form (Please fill out one form per student)

Legal Last First Name Middle	Gender	Birthdate	Home Phone	Family ID
Student Primary Address	City, State, Zip Code		School	Grade

Please contact your school nurse if your student has any health concerns that need to be addressed in the school setting.

Medical History

*Is your child **currently** being treated for any of the following? Please check all that apply.*

____ Asthma/Reactive Airway ____Seizure Disorder ____Bleeding Disorder ____ADD/ADHD
____Diabetes ____Bone/muscle disease ____Skin Condition ____Pregnancy
____Heart Condition ____Mental health condition (i.e., depression, anxiety, eating disorder) ____Other_____
____Yes ____No Does your child have any other health concerns which you feel it would be helpful for the school to know?
_____

Allergies

Is your child allergic to any of the following? Please check all that apply.

____Food (list what types of food) _____
____Medicine (list what types of medicine) _____
____Other _____
Describe what happens when your child has an allergic reaction: _____
Does your child need an Epi-Pen at school? ____Yes ____No If yes, the parent is required to supply school with an Epi-Pen.

Hearing/Vision

Do you have concerns about your child's vision? ____Yes ____No Does your child wear glasses or contacts? ____Yes ____No
Do you give permission for yearly vision screening? ____ Yes ___ No

Screenings

____Yes ____ No Permission for **Blood Pressure Screening** (Grades K-8) **Hearing** - Grades K-3,8 and referrals conducted by AEA 267 ____Yes ____ No
____Yes ____ No Permission for weekly **Fluoride mouth rinse** (Grades 1-4). Each week, under supervision, students will rinse with a 0.2% sodium fluoride mouth rinse.
____ Yes ____ No Permission **Height & Weight** – Grades K-8 (fall & spring) **Speech** –Referrals conducted by AEA 267, **Head Lice Screening**- as needed

Medication *Please list all of your student's medications.*

Name of Medication	Time medication is given	Reason for medication

Over-the-counter Medication

Do you want your child to receive over-the-counter medication at school? **____ Yes ____ No** *If no, continue to Insurance section*
If yes, please check which medications you want your child to receive:

___Acetaminophen (Tylenol) ____Benadryl ____Ibuprofen (Advil, Motrin) ___Antacids

Parent's Signature: _____ **Date signed**: _____
No more than 10 doses of over-the-counter medication will be given per year unless there is an order from a physician.

Insurance

Does your child have health insurance? ____Yes ____No *If yes, please check one that applies:*
☐ Private Provider _____ ☐ hawk i ☐ Medicaid # _____

In Case of Emergency

Please list the names and telephone numbers of people who can be called in case of illness or emergency.

Parent Name_____ Contact Numbers_____
Contact #1: Name_____ Contact Number_____ Relationship_____
Contact #2: Name_____ Contact Number_____ Relationship_____

Emergency Release

I give permission to the appropriate personnel of the Dike-New Hartford Community School District to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other Dike-New Hartford Community School personnel as needed.

Parent/Guardian Signature: _____ Date Signed: _____