

School Registration/Health Form

Please correct/add information below.

Student Information			
First Name:	Middle Name:	Last Name:	
Ethnic background:	Gender:	DOB:	Grade:
Home Phone:		SSN:	
Address:		Birth City:	Birth County:

Parent/Guardian Information	
Guardian:	Guardian:
Phone: (Work) (Cell)	Phone: (Work) (Cell)
Employer:	Employer:
E-mail address:	E-mail address:

Non-Custodial Parent:	Phone:
Address:	

Household Information <small>Please list the names and relationship to child of ALL who reside at student's residence.</small>			
Name	Relationship	Name	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Information <small>Please check all that apply.</small>	
<input type="radio"/> Seizures <input type="radio"/> Shunt <input type="radio"/> Glasses/Contacts <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Cerebral Palsy <input type="radio"/> Hearing Problems <input type="radio"/> Has inhaler to be carried at all times <small>(Requires Doctor's Order)</small> <input type="radio"/> Heart Condition <input type="radio"/> Attention Deficit <input type="radio"/> Headaches <input type="radio"/> Inhaler will be kept in nurse's office <small>(Requires Doctor's Order)</small> <input type="radio"/> Spina Bifida <input type="radio"/> Hyperactivity	<input type="radio"/> Allergies <input type="radio"/> Medicine <input type="radio"/> Allergy requiring EMERGENCY treatment or injection – Source of allergy: _____ <input type="radio"/> Food <small>(If a food allergy exists, a doctor's note of documentation will be required or state law requires that the food be offered in the lunch program.)</small> <input type="radio"/> Other _____ <input type="radio"/> Routine Medication: _____ <small>Is it necessary that your child take this at school? Y N (If yes, a doctor's order will be required BEFORE it is given.)</small>

Emergency contacts		
Name:	Phone:	Relationship:
Name:	Phone:	Relationship:
Physician:	Phone:	
In an emergency your child will be transported to the nearest hospital unless specified otherwise:		

If your child has a health concern, that information may be shared with other pertinent school personnel. By signing this form it is understood that you approve the above information to be shared on a need-to-know basis.

Parent/Guardian Signature _____ Date _____

Do not write below this line

Physical _____ Immunizations _____ Book Rental _____ Teacher/Homeroom _____
 Lead Screening _____ Birth Certificate _____ Bus Info: NA # _____ AM; # _____ PM