Glens Falls City School District
Glens Falls, New York 12801

HEALTH REGISTRATION FORM

Student's Name ________________________________ DOB ____________________

If you answer yes to any of the following, please provide details below. Include date(s), treatment prescribed, physician's name, and current status of problem.

	YES	NO		YES	NO
ADD/ADHD	____	____	Current Medication	____	____
Allergies: Medication/Food/ Environmental	____	____	Vision Problem	____	____
One Testicle/Kidney	____	____	Injury to the Spleen	____	____
Bee Sting Allergy	____	____	Fainted During Exercise	____	____
Asthma	____	____	Rapid Heartbeat	____	____
Anemia	____	____	Elevated Blood Pressure	____	____
Arthritis	____	____	Headaches	____	____
Frequent Colds/Ear Infections	____	____	Head Injury/Concussion	____	____
Ear Tubes	____	____	Heart Problem/Murmur	____	____
Pneumonia	____	____	Chest Pain	____	____
Chicken Pox	____	____	Nosebleeds	____	____
Scarlet Fever (Scarletina)	____	____	Joint Pain	____	____
			Back/Neck Pain	____	____
Bladder/Kidney Problems or Injury	____	____	Fractures/Dislocations	____	____
			Rheumatic Fever	____	____
Convulsions/Seizure	____	____	Stomach Ulcer	____	____
Fainting Spells	____	____	Orthodontic Appliance	____	____
Diabetes/Hypoglycemia	____	____	Exposure to TB	____	____
Hearing Difficulty	____	____	Hospitalizations	____	____
Emergency Room Visit	____	____	Surgery	____	____
Other	____	____			

Family Physician or Pediatrician: ____

Medical information details (Include significant birth history, disabilities, speech difficulties etc.)

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____

____

1. Is your child presently taking medication? ____ yes ____ no

For what reason? ____

2. Has your child ever been evaluated for O.T._____, P.T. _____, Speech ____
   Psychological Issues ______ ?
   Please explain ____

   ____

   ____

3. Has your child ever seen a dentist? _____yes _____no

   If so for what reason ____

4. Should your child be restricted from participating in school gym or sports? _____yes _____no
   If yes, you must provide written recommendations from your child's physician.

5. Additional Comments: ____

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Date __________ Parent/Guardian Signature ____