Glens Falls City School District

Glens Falls, NY 12801

HEALTH REGISTRATION FORM

Student's Name:_____ DOB_____

If you check 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	___	___	Head Injury/Concussion	___	___
			Heart Problem/Murmur	___	___
Bee Sting Allergy	___	___	Fractures/Dislocations	___	___
Asthma	___	___	Orthodontic Appliance	___	___
Arthritis	___	___	Surgery	___	___
Ear Tubes	___	___	Migraines	___	___
Bladder/Kidney Problems	___	___	Glasses/Contacts	___	___
Convulsions/Seizures	___	___	Other _____	___	___
Diabetes/Hypoglycemia	___	___			

_____

_____

_____

_____

_____

_____

Family Physician or Pediatrician: _____

1-Medical information details (Included significant birth history, disabilities, speech difficulties, etc.): _____

_____

Is your child presently taking medication? ____YES ____NO

*If yes: what medication (s) and for what reason(s)?*_____

_____

_____

Is the medication administered during the school day? ____YES ____NO

2-Does your child have allergies?

FOOD:_____

MEDICATION:_____

ENVIRONMENTAL:_____

3-Has your child been evaluated for or received any of the following services: Speech, OT, PT, Counseling? If so, please explain:_____

_____

4-Has your child ever seen a dentist? ____YES ____NO

*If so, for what reason:*_____

5-Should your child be restricted from participating in school gym or sports? ____YES ____NO

If yes, please provide written recommendations from your child's physician.

6-Additional Comments: _____

_____

_____

_____

Date: _____ **Parent/Guardian Signature**_____