GLOVERSVILLE ENLARGED SCHOOL DISTRICT

HEALTH SERVICES

Health Registration Record

School_____ **Date**_____

Student's Full Name_____ **Female** ☐ **Male** ☐

Student's Birth Date_____

Student's Address_____ **Phone #**_____

Mother's Full Name (include maiden name)_____

Father's Full Name_____

Brothers/Sisters	**Date of Birth**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Doctor_____ NA ☐ Dentist _____ NA ☐

School Last Attended_____ **Grade**_____

Has your child ever attended a Gloversville School? Y ☐ **N** ☐ **If so, which school?**_____

Immunizations

Please see attached form regarding NYS Immunization Requirements for School Entrance/Attendance for a complete listing of immunizations that are required depending on grade level and age. If you have any questions please contact the school nurse.

Student History:

1. **Did mother experience any complications during the pregnancy? Yes** ☐ **No** ☐ **If yes, please explain**
   _____
2. **Was child full term? Yes** ☐ **No** ☐ **If premature, how early?** _____
3. **Was the child healthy at birth? Yes** ☐ **No** ☐ **Birth Weight**_____ **lbs.** _____ **oz.**
4. **Did the child experience any problems at birth? Yes** ☐ **No** ☐
   Please explain
5. **Did your child have any problems learning to talk, walk, or toilet train? Please explain:**
   _____
   _____

6. Please check if your child had or has any of the following:

COMMENTS

ADHD/ (Diagnosed by a doctor)	Yes ☐	No ☐
Allergies***	Yes ☐	No ☐

(**Life Threatening allergies must have medical documentation)**

Anemia	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Bladder/Bowel Problem	Yes ☐	No ☐
Chicken Pox	Yes ☐	No ☐
Contact with Tuberculosis	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Skin Problem	Yes ☐	No ☐
Frequent ear/hearing problem	Yes ☐	No ☐
Frequent headaches/migraines	Yes ☐	No ☐
Frequent Nosebleeds	Yes ☐	No ☐
Heart Problems	Yes ☐	No ☐
Kidney/Urinary Problem	Yes ☐	No ☐
Physical disability	Yes ☐	No ☐
Seizure Disorder	Yes ☐	No ☐
Speech Problem	Yes ☐	No ☐
Thyroid/growth problem	Yes ☐	No ☐
Glasses/vision problem	Yes ☐	No ☐
Other	Yes ☐	No ☐

7. Current medications your child is taking: _____

_____

8. Hospitalizations (dates and reasons): _____

9. Will your child need any modification of school activities? Yes ☐ No ☐ If yes, please explain: _____

_____

_____

10. Has your child received any specialized medical testing or treatments? Yes ☐ No ☐ If yes, please explain:

_____

11. Family History:

Please indicate any that apply to your immediate family (parent, sibling, grandparent, uncle, aunt)
(must be diagnosed by a doctor)

ADD/ADHD _____

Allergy _____

Depression _____

Developmental disability _____

Diabetes _____

Hearing Problem _____

Heart _____

Physical disability _____

Seizure disorder _____

Scoliosis _____

Vision problem _____

Signature _____ **(Rev. 1/20/15)**

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