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_____Dentist_____

School Last Attended_____Grade_____

Has your child ever attended a Gloversville School? ___ Which School?_____

Immunizations

The following immunizations are required by New York State Law:

DPT – 3 Doses

Polio – 3 Doses

MMR – 2 Doses MMR (measles, mumps, rubella) OR 2 Doses Measles and 1 Dose of Mumps and Rubella

Hep. B – 3 Doses

Varicella – 1 Dose if born on or after 1/1/98

Hib – 3 Doses (Headstart and Pre-K students only)

Please provide proof of all immunizations with a medical certificate from a doctor, health clinic or previous school records. Failure to provide proof of immunizations within 14 schools days may necessitate exclusion of your child from school.

Student History:

1. **Did mother experience any complications during the pregnancy? _____ If yes, please explain _____**
2. **Was child full term?_____ If premature, how early? _____**
3. **Was the child healthy at birth? _____ Birth Weight_____ lbs. _____ oz.**
4. **Did the child experience any problems at birth? _____ Please explain_____**
5. **Did your child have any problems learning to talk, walk, or toilet train? Please explain:_____**

-OVER-

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

		COMMENTS
ADD/ADHD (Diagnosed by a doctor)	( )	_____
Allergies*****	( )	_____
(**Life Threatening allergies must have medical documentation)**		
Anemia	( )	_____
Asthma	( )	_____
Bladder/Bowel Problem	( )	_____
Chicken Pox	( )	_____
Contact with Tuberculosis	( )	_____
Diabetes	( )	_____
Skin Problem	( )	_____
Frequent ear/hearing problem	( )	_____
Frequent headaches	( )	_____
Frequent nosebleeds	( )	_____
Heart Problems	( )	_____
Kidney/Urinary Problem	( )	_____
Physical disability	( )	_____
Seizure Disorder	( )	_____
Speech Problem	( )	_____
Thyroid/growth problem	( )	_____
Glasses/vision problem	( )	_____
Other	( )	_____

7. Current medications your child is taking: _____

_____

8. Hospitalizations (dates and reasons): _____

9. Will your child need any modification of school activities? _____ Please explain

_____

_____

10. Has your child received any specialized medical testing or treatments? ____ Please explain _____

_____

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)**