To be completed by parent/guardian.

PUPIL REGISTRATION
PELHAM PUBLIC SCHOOLS
PELHAM, NEW YORK

PARENT HEALTH & INFORMATION SURVEY

Student ______________________________ Date ______________________________

Address ______________________________ Home Phone ______________________________

School ______________________________ Date of Birth ______________________________

Grade/Class ______________________________ Place of Birth ______________________________

Parent Name (1) ______________________________ Parent Name (2) ______________________________

Parent Occupation (1)______________________________ Parent Occupation (2) ______________________________

Business/Cell Phone (1) ______________________________ Business/Cell Phone (2)______________________________

Physical Exam has/will be done by Dr. ______________________________ on ______________________________
(Mandatory Grades K, 2, 4, 7,10)

Is there anything concerning your child's health that the school should know to provide necessary care?

If yes, please explain ______________________________

Does your child wear glasses? ________ Date of last examination ____________ by Dr. ______________________________

Has your child had any illness or operations since the last school year?

If yes, please explain ______________________________

Does your child take any medication? ______________ Name/Dosage of Medication ______________________

Allergies to medication (type)______________________ **Allergies to food** (type) ______________________

Allergies to environment/other __________________

EMERGENCY INFORMATION

Local people/babysitter to be called in the case of an emergency or illness when a parent/guardian is not available:

Name ______________________________ Home Phone ______________________ Cell ______________________

Name ______________________________ Home Phone ______________________ Cell ______________________

Doctor to be called if necessary:

Name ______________________________ Address ______________________________ Phone ______________________

Dentist to be called if necessary:

Name ______________________________ Address ______________________________ Phone______________________

Preexisting Dental Conditions ______________________________

OVER Rev.12/16

Has the child had any of the following? Please check and give approximate dates.

Chicken Pox ________________

Tuberculosis ________________

Tuberculosis in Family ________________

Diabetes ________________

Scoliosis ________________

Hepatitis ________________

Blood Disorders ________________

Asthma ________________

Hay Fever ________________

Hives ________________

Heart Condition ________________

Seizure Disorder ________________

Ear Infection ________________

Operations/Accidents ________________________________

Any other existing conditions or significant past medical history

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DISTRICT MEDICATION POLICY

When a child needs to take medication at school, ALL medication MUST:

1. Be prescribed by a licensed prescriber
2. Be labeled with the child's and physician's name by the pharmacy
3. Have directions for dispensing on the bottle
4. Be accompanied by permission note from parent or guardian

Transfer of student health records: I hereby authorize the release of a copy of the student health records of my child in the event of his/her transfer to another school district.

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Signature of Parent/Guardian