KILLINGLY PUBLIC SCHOOLS
Great Things Happen Here!

Student Health Information

PLEASE READ CAREFULLY AND PRINT CLEARLY: Fill out **ALL** the information below, sign, and return to the main office.

☐ KPS Pre-School ☐ KMS ☐ KCS ☐ KIS ☐ KHS Current Grade: _____ __ __ __ __ __ __ __ __ __ __
State Student ID (if known)

Name: _____ _____ _____
Last First Middle

Birth Date: _____ ☐ Male ☐ Female ☐ Other Gender Identification

Last School Attended: _____

_____ _____ _____ _____
Street City State Zip Code

Does your child have health insurance? ☐ Yes ☐ No Policy #_____

Health Insurance Carrier ☐ Husky ☐ BC/CS ☐ Health Net ☐ Other _____

Check if your child had a specialized plan for medical or educational management in school. ☐ IEP ☐ 504 ☐ IHP

Explain: _____

Doctor's Name _____ Doctor's Phone # _____

Dentist's Name _____ Dentist's Phone # _____

Date of last Physical exam _____ Date of last Dental exam _____

☐
Parent/Guardian Initials

I, the undersigned, do hereby authorize officials of the **Killingly Public School District** to contact directly the medical personnel named on this form and do authorize them to render such treatments to this child as may be deemed necessary in an emergency. I will not hold the school district financially responsible for the emergency care or transportation of this child.

Does your child wear glasses? ☐ Yes ☐ No If yes, Glasses worn for ☐ Reading ☐ Distance ☐ Full time wear

Does your child have Asthma? ☐ Yes ☐ No If yes, what triggers it? ☐ Illness ☐ Allergy ☐ Exercise ☐ Cold air

Please describe your child's asthma symptoms: _____

Names of asthma medications (dosage and frequency) given at home: _____

Does your child take any medications on a daily basis? ☐ Yes ☐ No

Name of Medication _____ Dosage _____ Reason _____

Are there any problems in the home at this time that might affect your child's learning?

_____

Describe any behavior problems that your child has that you are concerned about:

_____

Please list, with detail, any other concerns regarding your child's health that you feel school personnel should be aware of:

_____

_____

_____

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Allergies

Does your child have any allergies that are listed below? If so, please check box and list type

☐ Insect Sting _____ ☐ Environment _____

☐ Food _____ ☐ Medications _____

☐ Animals _____ ☐ Other _____

Please check the signs that are usually present with allergic reaction.

☐ Difficulty Breathing ☐ Loss of consciousness ☐ Swelling

☐ Difficulty Swallowing ☐ Flushed or unusually pale How much? _____

☐ Rash ☐ Nausea Where? _____

Other: _____

Please list medications to control allergic reactions.

Medication	Amount Taken	When Given
_____	_____	_____
_____	_____	_____

History

Does your child have any physical limitations or restrictions on activity? ☐ Yes ☐ No

Explain: _____

Has your child had any accidents or operations since birth? ☐ Yes ☐ No

Explain: _____

Has your child had or been diagnosed with any of the following? Please check Yes or No for each one.

	Yes	No		Yes	No
Frequent Stomachaches	☐	☐	Seizures	☐	☐
Frequent Colds	☐	☐	Diabetes	☐	☐
Frequent Headaches	☐	☐	Eczema	☐	☐
Migraine Headaches	☐	☐	Lyme Disease	☐	☐
Frequent Ear Infections	☐	☐	ODD	☐	☐
Ear Tubes	☐	☐	Mumps	☐	☐
Frequent Constipation	☐	☐	Measles	☐	☐
Incontinence (Bladder or Bowel)	☐	☐	Polio	☐	☐
Strep Throat	☐	☐	Chicken Pox	☐	☐
Rheumatic Fever	☐	☐	Epilepsy	☐	☐
Scarlet Fever	☐	☐	Tuberculosis	☐	☐
Bronchitis	☐	☐	Cancer	☐	☐
Pneumonia	☐	☐	Heart Disease	☐	☐
Speech Problem	☐	☐	ADD or ADHD	☐	☐
MRSA	☐	☐	Anxiety	☐	☐

Other: _____

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Family History

Please indicate the relationship of any close relative to the student whom has a history of any of the following

Diabetes	_____	Cancer	_____
High Blood Pressure	_____	Anemia	_____
Seizure Disorder	_____	Sickle Cell Anemia	_____
Learning Problem	_____	Developmental Delays	_____
Birth Defect	_____	Heart Disease	_____

Other: _____

Preschool and Kindergarten Registration Only

Does your child have frequent ear infections? ☐ Yes ☐ No Date of last hearing test _____

Name of M.D. _____ Results found _____

Does your child have tubes in their ears? ☐ Yes ☐ No Date of insertion: _____

Does your child wear glasses? ☐ Yes ☐ No Date of last eye exam _____

Name of Dr. _____ Results found _____

Has your child ever had surgery on their eye(s)? ☐ Yes ☐ No Date of surgery: _____

Has your child ever had a program for eye patching? ☐ Yes ☐ No

Is bedwetting a problem? ☐ Yes ☐ No

Does your child have wetting accidents during the day? ☐ Yes ☐ No

Does your child have occasional accidents with bowel movements? ☐ Yes ☐ No

Does your child take medication for constipation? ☐ Yes ☐ No

Name of medication, frequency, and time given _____

Does your child wear diapers? ☐ Yes ☐ No When: _____

During pregnancy with this child, did the mother have any medical problems? ☐ Yes ☐ No

If yes, describe type of problem _____

Were there any problems during labor or delivery? ☐ Yes ☐ No

If yes, describe type of problem _____

Did child breathe right away? ☐ Yes ☐ No Birth weight? _____

Did this child leave the hospital when the mother left? ☐ Yes ☐ No

Please write the age that your child did the following:

Walk alone _____ Talk (with 2 words together) _____ Daytime toilet trained _____

I confirm that the information contained on this registration is current and accurate.

_____ _____ _____

Parent/Guardian Signature | Parent/Guardian Name (please print) | Date