WATERTOWN CITY SCHOOL DISTRICT
Central Registration
1351 Washington St, Watertown NY 13601

Phone: (315) 661-8338
Fax: (315) 785-6855

Student Name:	DOB: Grade:	Gender: ☐M ☐F
Parent/Guardian Name:	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐nsect ☐medication ☐ther
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ADHD
☐Asthma/trouble breathing
☐Autism/Asperger
☐Dental Injuries
☐Diabetes
☐Ear Infections
☐GI Conditions(ulcer, reflux, IBS)
☐Headaches/migraines
☐Heart Conditions
☐High Blood Pressure
☐Mental HealthCondition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐Scoliosis
☐Single Organ (☐kidney,☐testicle)
☐Skin Condition
☐Speech Condition
☐Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐nhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?

☐No ☐Yes:_____

Please list any additional concerns: (use back of sheet if necessary)_____

_____

Please provide the nurse's office with a copy of your child's immunization and current Physical from their medical provider.

If you are unavailable and your child needs to go home because of illness or injury, whom do we contact?

Name _____

Last Name First Name Address Phone Number E-Mail Address

Name _____

Last Name First Name Address Phone Number E-Mail Address

I give permission for medical and emergency information about my child to be shared with Appropriate staff. I also give permission to the school nurse to have my child transported To an emergency medical facility if deemed necessary.

Parent/Guardian Signature:_____Date:_____