# Student Health Information

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

Parent Name: ______________________________ Parent Phone: ______________________

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

Student Name: ______________________ ______________________ ______________________
Last First Middle

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

Last School Attended: ______________________________________________

______________________ ______________________ __________ __________
Street City State Zip Code

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

Explain: ______________________________________________

Date of last Physical exam ____________________ Date of last Dental exam ____________________

Parent/Guardian Initials

I, the undersigned, do hereby authorize official of he **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

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:

______________________________________________

______________________________________________

______________________________________________

KILLINGLY PUBLIC SCHOOLS
*Great Things Happen Here!*

# Student Health Information

## 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: ______________________________________________

# Student Health Information

## 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