

HEALTH INFORMATION REGISTRATION FORM

School: _____

Grade Entering: _____

Student's Name: _____ DOB: _____

Mother's Name: _____ Father's Name: _____

Guardian's Name: _____ Relationship: _____

Address: _____

Telephone Numbers: _____ Home Telephone: _____

Guardian/Mother's Cell: _____ Guardian/Father's Cell: _____

Guardian/Mother's Work: _____ Guardian/Father's Work: _____

**In case of an emergency or illness please print the name/s of all those that you
would trust to pick up your child at school in your absence**

Emergency Numbers:

Name: _____ Relationship: _____ #: _____

Name: _____ Relationship: _____ #: _____

OFFICE USE BELOW HEALTH REQUIREMENTS FOR ENTRY INTO WATERBURY PUBLIC SCHOOLS

☐ Student has a health assessment within the last year but will require a current health assessment during the next school year. Date of last physical examination: _____

☐ No current health assessment (physical examination). An appointment date has been made.
Appointment Date: _____ Physician's Name: _____

The following immunizations are required prior to your child entering school:

☐ Dtap / Tdap # _____	☐ Pneumococcal # _____	☐ MCV # _____
☐ IPV # _____	☐ HIB # _____	☐ PPD: _____
☐ MMR # _____	☐ HAV # _____	
☐ Varicella # _____	☐ HBV # _____	☐ Lead Test: _____

I understand that my child requires the above specified health requirements to fulfill the State of Connecticut health mandates for entry into school. If these requirements are not fulfilled I understand my child will be excluded from school until they are completed. In the case of a physical examination, if the form is not returned to school on the day after the appointment date your child will be excluded from school.

Parent's Signature: _____ Date: _____

Intake Staff: _____ Date: _____

☐ All health requirements are complete McKinney Vento Act: Yes / No

Parent's Signature: _____ Date: _____

Intake Staff: _____ Date: _____

WATERBURY PUBLIC SCHOOLS INTAKE CENTER HEALTH HISTORY

Dear Parent/Guardian: Please fill out this form as accurately and completely as possible. This will enable the Waterbury School District to plan for both your child's educational and health needs.

Estimado Padre/Encargado: Por favor llene este formulario en su totalidad y con la mayor precisión posible. Esto permitirá que el Distrito Escolar de Waterbury pueda planear para las necesidades académicas y de salud de su hijo.

Does your child have any of the following health problems: **Circle Yes or No**
¿Su niño tiene cualquiera de los siguientes problemas de salud: **Marque Sí o No**

	Yes-Si	No		Yes-Si	No
Asthma / Asma			Wears a hearing aid / Usa aparatos auditivos		
Uses Inhaler / Usa Inhalador			Heart Problems / Problemas del Corazón		
Uses Nebulizer / Usa nebulizador			Kidney Problems / Problemas de los riñones		
Breathing difficulties / Dificultad respiratoria			Was born premature/early / Nació prematuro		
Seizures / Convulsiones			Bone Problems / Problemas de los huesos		
Headaches / Dolores de cabeza			Anemia / Anemia		
Concussions to head / Conmociones en la cabeza			Sickle cell anemia / Anemia de células falciformes		
Hearing Problems / Problema de Audición			Bleeds easily/Nose bleeds / Sangra con Facilidad/Sangrados de Nariz		
Ear Infections / Infecciones de oído			Was in hospital for 1+ weeks after birth/ Hospitalizado 1 o más semanas después de nacer		

Allergies Yes No Epi-pen required? Yes No
 Alergias Si No Epi-Pen es Requerido? Si No
 Allergic to specific foods: _____
 Alérgico a Alimentos Específicos: _____
 Insects: _____ Insectos: _____
 Pollen: _____ Polen/Arboles: _____
 Other: _____ Otro: _____

Takes medication daily Yes No Will need to take medication in school Yes No
 Toma medicamentos Diarios Si No Necesita tomar medicamentos en la escuela Si No

Medication Names: _____
 Nombres de los medicamentos: _____

Has had operations Yes No Ha tenido operaciones Si No
 Describe/Dates: _____
 Describa las fechas: _____

Has trouble eating food Yes No Has trouble swallowing food Yes No
 Tiene dificultad para comer alimentos Si No Tienes dificultad para tragar los alimentos Si No

Needs to be catheterized Yes No Wears diapers Yes No
 Necesita ser cateterizado Si No Usa pañales Si No

Can go to the bathroom alone Yes No Needs help with toileting Yes No
 Puede ir al baño solo/a Si No Necesita ayuda para usar el baño Si No

Health Concerns/Preocupaciones de Salud: _____

Physician's Name: _____ Hospital preferred: _____
 Nombre del médico: _____ Hospital preferido: _____

Parent/Guardian's Signature: _____ Date: _____
 Firma del Padre/Encargado: _____ Fecha: _____