



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 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:

Student Health Information

Allergies

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

- | | |
|---|--|
| <input type="checkbox"/> Insect Sting _____ | <input type="checkbox"/> Environment _____ |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Animals _____ | <input type="checkbox"/> Other _____ |

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

- | | | |
|--|--|-----------------------------------|
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Flushed or unusually pale | How much? _____ |
| <input type="checkbox"/> Rash | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Lyme Disease	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	ODD	<input type="checkbox"/>	<input type="checkbox"/>
Ear Tubes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence (Bladder or Bowel)	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>	ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>

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 _____