

City of Newton



Setti D. Warren
Mayor

HEALTH AND HUMAN SERVICES DEPARTMENT

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Public Health
Prevent. Promote. Protect.

STUDENT MEDICAL REGISTRATION FORM ~ TO BE COMPLETED BY PARENT

Child's Name _____ Sex: M { } F { } Date of Birth: _____ Grade: _____

Student's Primary Language _____ School _____

Siblings (names and ages) _____

Home Address _____ Home Phone _____

Parent/Guardian _____

Home Address (if different) _____

Work Address _____ Work Phone _____ Cell _____

Parent/Guardian _____

Home Address (if different) _____

Work Address _____ Work Phone _____ Cell _____

Name and Address of previous school attended _____

Physician's Name and address _____ Phone _____

Do you currently have health insurance? Yes { } No { } Name of Insurer _____

Pre-Natal History

Pregnancy, Birth, Early Infancy: Were there any problems that you think might be pertinent to your child's growth and development? _____

Health History

Does your child have:

Y N

Completed Immunizations - **Attach complete immunization record**

Lead screening test- Included in physical examination record

Allergies to food – describe _____

Allergies to medication – describe _____

Allergies to other – describe _____

Does your child need treatment for these allergies? Yes { } No { } Explain: _____

History of Anaphylaxis EpiPen® Yes { } No { }

Asthma/Reactive airway disease - List triggers: _____

What is the current treatment plan? _____

Attach *Massachusetts Asthma Action Plan* if available

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Does your child have any of the following:

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox – Date_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Issues	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Vision Difficulty – Glasses { }
<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty – Hearing Aid { }
<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Difficulties/Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	ADD, ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Lactose Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Problems - Constipation { }			

If yes to any of above, describe fully: _____

Medications

List all medications your child is taking:

Medication _____ Dose _____ Time(s) taken _____

Medication _____ Dose _____ Time(s) taken _____

Medication _____ Dose _____ Time(s) taken _____

Circle medications to be administered during school.

A separate Medication Permission Form is needed for each medication.

Behavioral/Coping History

Is there any information that would be useful for the staff to help your child at school? _____

Family History

Are there any family situations or health conditions that could have an effect on your child? _____

A physical examination and immunization record by a health care provider is required for all kindergarten, sixth grade and newly enrolled students. Evidence of a lead-screening test is required for all students entering kindergarten.