# AUBURN ENLARGED CITY SCHOOL DISTRICT
# SCHOOL HEALTH SERVICES
## Pre-Kindergarten and Kindergarten Registration Health Form

**Student Last Name:** _____ **Student First Name:** _____

**Date of Birth:** _____ **Place of Birth:** _____

**Sex: M____ F____ Grade:** ***(circle one)*** **3PK UPK K School:** _____

**Student Address:** _____

In case of accident or illness, it is mandatory that you provide the following information for emergency calls:

| Name | Last | First | Address | Home/Cell Phone | Work Name | Work Phone |
|---|---|---|---|---|---|---|
| **Mother** | | | | | | |
| **Father** | | | | | | |
| **Step Parent** | | | | | | |
| **Step Parent** | | | | | | |

List TWO persons (relatives/babysitter/neighbor) who will assume temporary care of your child if you cannot be reached:

| Name | Relationship | Address | Home/Cell Phone | Work Name | Work Phone |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

**Physician Name:** _____ **Dentist Name:** _____

**MEDICAL HISTORY**

***Has child, or any immediate family member (Parents/Grandparents) had a history of:***

Diabetes _____
Heart Disease _____
Seizures _____
Sickle Cell Trait _____
Sudden Cardiac Death _____

***Has child had: (Provide dates)***

RSV _____ Scarlet Fever _____
Chicken Pox _____ Rheumatic Fever _____
Pneumonia _____ Pertussis _____

Surgery _____ Serious Injury _____
Broken Bones _____ Head Injury _____
Loss of Consciousness _____

***Does child have any problem with:***

Constipation _____ Diarrhea _____ Bedwetting _____
Frequent Urination _____ Is your child potty trained _____

***Does child contract frequent: (More than 4-5 per year)***

Sore Throats/Strep Infections _____

Earaches/Ear Infections _____ Under care of Dr. _____
Tubes in ears _____ Date of insertion _____
Skin Rashes/Eczema _____
Headaches _____ Stomachaches _____

***Does child have:***

Asthma/Wheezing _____
Under care of Dr. _____ Medication _____

Allergies: *(circle all that apply)* Food Insect bites Medications Other
Describe allergens/reactions: _____
**Has child ever been stung by a bee?** Yes ____ No ____
If yes, describe reaction: _____

Heart Murmur _____ Under care of Dr. _____

Seizure Disorder _____ Under care of Dr. _____
Medication _____ Date of last seizure _____

Vision Problems _____
Under care of Dr. _____ Glasses: Yes ____ No ____
Last appointment _____

Hearing Problems _____
Under care of Dr. _____ Hearing aids: Yes ____ No ____
Last appointment _____

Are there any other medical problems or concerns that the school should be aware of: _____
_____
_____

Does child take any medication on a regular basis? _____
_____

In case I cannot be reached, I authorize the Auburn School District to render such treatment as may be necessary in an emergency for the health of my child. I give my permission to the school official in charge to obtain the services of the nearest ambulance, rescue service, family physician on record, or other physician if my own is not available, to provide immediate and necessary care. This form will be utilized for the current school year. The information will be shared with appropriate instructional staff, the transportation department, and Health Services. It will also be available on field trips and in the event of an emergency will be given to emergency personnel.

**Date: _____** **Signature of Parent/Guardian X _____**

* If any of the above information changes during the course of the school year, please notify the School Nurse, as soon as possible. ***NYS Education Law requires school districts to have on file signed instructions for emergencies from parents/guardians.***

***For Office Use Only***
*If **Kindergarten Registrant**, did parent/guardian provide:*

| | | | | | |
|---|---|---|---|---|---|
| Physical Exam | ___ | Date of Exam:_____ | ___ | Release of Information signed |
| Dental Certificate | ___ | Date of Exam: _____ | ___ | Renewed-Received Emergency Action Plan (date: ____) |
| Immunizations | ___ | Up to date: _____ | ___ | Reviewed and Received Medication Policy and Order Sheet |
| | | | ___ | Reviewed Immunizations, Physical and Dental requirements |

**Reviewed by: (Nurse) _____**
**Date of Interview/Form Completion: _____**