

NEW STUDENT HEALTH REGISTRATION FORM

Dear Parents/Guardians,

Welcome to St. Joseph School! To expedite your registration, please complete this form and return it along with your child's immunization record when registering. In order to best meet your child's needs, it is helpful if we are informed of any/all health issues/history your child may have. This information will be shared with the appropriate school personnel working with your child during each year and your child will have a confidential medical file in the nurse's office. It is imperative that you keep the nurse/teachers informed of any changes with your child's health. If you anticipate your child needing medication at school (*over-the-counter or prescription*), a physician's order is required-please contact the nurse for details (also, refer to the handbook). I look forward to working with you and your child. If you have questions, concerns, or need to discuss specific issues with me, do not hesitate to contact me via phone or e-mail (see website). Thank you!

Mary Konopacki RN, BSN

Today's date _____ Grade entering _____ Last school attended _____
Student Name _____ Date of Birth _____
Address _____ Home phone _____
Mom's Name _____ Cell phone _____ Work phone _____
Dad's Name _____ Cell phone _____ Work phone _____
Emergency contact(s) for illness in the event parent can not be reached:
Name _____ Home phone _____ Cell phone _____
Name _____ Home phone _____ Cell phone _____

MY CHILD HAS THE FOLLOWING HEALTH PROBLEMS: (address **each** w/ **X** for No **or** **✓** for Yes)

____ Food Allergy, please describe _____
____ Nut Allergy (specify nut type) _____ Severity of reaction, describe/Tx _____
____ Medications required for food allergy ***(request med order form for school)** _____
____ Drug Allergy, please list _____ Other Allergies (i.e. seasonal) _____
____ Seasonal Allergies, treatment/describe _____
____ Bee Sting Allergy: never stung _____ stung, no problems _____ strong family history _____
____ Asthma- triggers _____ Treatment ***(request med order form for school)** _____
____ Bleeding disorders, please describe _____
____ Diabetes _____ Treatment _____
____ Heart problems _____ Restrictions _____
____ Hearing deficits _____ Vision deficits _____ Glasses/contacts _____
____ Chicken Pox or other Infectious diseases (describe) _____
____ ADD _____ Medication _____ Counseling _____
____ ADHD _____ Medication _____ Counseling _____
____ Emotional/adjustment concerns _____ Counseling _____
____ Parents separated(when occurred _____) any concerns _____
____ Daily medications(if so, list) _____ Medications as needed _____
____ Special seating requirements, or restrictions in activities(explain) _____
____ Speech deficits _____ Treatment/therapy _____
____ Specific health concerns or needs not listed above. Please explain _____
____ Birth/Development/Milestones-History/issues _____

Parent's Signature _____ Date _____

***** Please note:** all **NEW STUDENTS** must provide the following **before** beginning school:
Current Immunization record, Health Inventory signed by a physician, and Dental form