CLARKSTOWN CENTRAL SCHOOL DISTRICT

HEALTH SERVICES REGISTRATION FORMS

Dear Parent/Guardian:

Welcome to the Clarkstown Central School District.

Please fill the attached forms **COMPLETELY** (3 pages). Return them to the registrar before you leave today. This information is essential for the school nurse to care for your child.

- Include **ALL** special health needs
- Include **ALL** allergies
- Include **ALL** medications that need to administered in school
- Immunization records **MUST** be completed before a student can enter school. Leave a copy if you have it with you, as well as any other medical documents.
- The registrar will give you another packet. Please return those forms to your school nurse when school opens.

A school nurse will call you to review the information.

The best daytime phone number to reach you: ____________________________

Name ____________________________

Very truly yours,

Susan J. Sherlock, P.N.P.
Coordinator of Health Services
Child’s Name: ___________________________ Date of Birth: ______________

Mother’s Name: ________________________ Place of Employment: ______________
   Cell Phone Number: ________________ Work Phone Number: ________________
Father’s Name: ________________________ Place of Employment: ______________
   Cell Phone Number: ________________ Work Phone Number: ________________

BEST Phone Number For Nurse To Reach Parent/Guardian: ______________________

If parents are unavailable when child is ill call: ____________________________
   Relationship: __________________________ Phone Number: ________________
   Additional emergency contact: __________________________ Phone Number: ________________

BIRTH/DEVELOPMENTAL HISTORY

Pre-natal: Uneventful: __________ Complications: (describe) ________________

Premature at: __________ months
   Complications: (describe) ________________

Birth Weight __________

Apgar Score: (if known) 1 minute __________ 5 minutes __________

Developmental:
   Sat alone ________ months Stood alone ________ months
   Crawled ________ months Walked ________ months
   Toilet trained: Average ________ Delayed ________
   Comments: ____________________________
   Speech: Average ________ Advanced ________ Delayed ________
   Comments/Therapy: ____________________________
   Motor Skills: Average ________ Advanced ________ Delayed ________
   Comments/Therapy: ____________________________
   Activity Level: Average ________ High ________
   Comments: ____________________________

Social Development:
   Tolerates Change in Routine: No Problem ________ Has Difficulty ________
   Describe: ____________________________
   Interaction with Peers: No Problem ________ Has Difficulty ________
   Describe: ____________________________

Excessive Fear or Anxieties: (describe) ____________________________

Special Dietary Concerns: (describe) ____________________________
CLARKSTOWN CENTRAL SCHOOL DISTRICT
CHILD MEDICAL HISTORY INFORMATION
(To be completed by Parent or Guardian)

Information is confidential and may be shared with teaching staff as needed.

Child’s name: __________________________ Date of Birth: ________ Boy ☐ Girl ☐ Grade: ________

Address: ___________________________________________ Home Phone Number:__________________

Lives at home with:
(Name) _______________________; Mother (Name) _______________________; Father

Siblings/Other: (Name) _____________________; Male ☐ Female ☐ Date of Birth ________; Relationship:__________

(Name) _____________________; Male ☐ Female ☐ Date of Birth ________; Relationship:__________

(Name) _____________________; Male ☐ Female ☐ Date of Birth ________; Relationship:__________

Child’s Caretaker: (Name) _______________________; Male ☐ Female ☐ Relationship:__________

Doctor’s Name: ___________________________ Phone Number:_____________ Date of last physical:__________

Dentist’s Name: ___________________________ Phone Number:_____________ Date of last visit:__________

Is child under an orthodontist’s care? No ☐ Yes ☐ Doctor’s Name:_________________________

Is child under the care of any specialist? No ☐ Yes ☐ Doctor’s Name:_________________________ Specialty:__________

Has this child ever had (a): YES Date: YES Date:
Chicken Pox ☐ _______________ Meningitis ☐ _______________
Encephalitis ☐ _______________ Rheumatic fever ☐ _______________
Lyme disease ☐ _______________ Pneumonia ☐ _______________
Bleeding tendency ☐ _______________ Kidney disease ☐ _______________
High Blood Pressure ☐ _______________ Positive TB test ☐ _______________

If Yes: Was medication ordered? ________

Any complications from above illnesses? (Please explain)__________________________________________

__________________________________________________________________________________________

Does child have or has child ever had:

■ Allergies? Yes ☐ Drug____________________ Food____________________

Insects____________________ Environmental____________________

Has the allergy required emergency action in the past? No ☐ Yes ☐

__________________________________________________________________________________________

What happens to child:

__________________________________________________________________________________________

■ Asthma? Yes ☐ Triggered by:____________________ Treatment:____________________

Uses: Inhaler ☐ Nebulizer ☐ Other medication ☐

Taken: at home only ☐ may need medication at school ☐
Diabetes? Yes □ Takes insulin? No □ Yes □ Pump? No □ Yes □

Seizures? Yes □ Describe seizure: ____________________________________________
Date of last seizure: __________________________ Medication: __________________________

Heart condition, murmur, or irregular heart beat? Yes □ Describe ____________________________________________
Describe physical restrictions? ____________________ Medication? No □ Yes □

Previous head injury? Yes □ At age: ________ Concussion? Yes □ Dates: __________

Headaches/Migraines? Yes □ Describe any Aura: ____________________________ Medication? Yes □ No □
Name of medication: ____________________________________________________________

Dizziness, loss of consciousness, fainting or lost memory? Yes □ Describe: ____________________________________________

Bone or joint problems or broken bones? Yes □ Describe: ____________________________________________
Any physical restrictions? __________________________________________________________

Loss of an eye, kidney, testicle or other organ? Yes □ Describe: ____________________________________________

Past history of increased lead levels in the blood? Yes □ When? ________ Was it treated? __________

Attention Deficit Disorder? Yes □ Is your child taking medication for this now? No □ Yes □
Name of medication: ____________________________________________________________
Taken: at home only □ may need medication at school □

Has this child had any other illness? __________________________________________

Does your child take any other daily medication at home? No □ Yes □ At school? No □ Yes □
Name of medication: __________________________ Reason for taking it: __________________________

ALL MEDICATIONS ADMINISTERED AT SCHOOL REQUIRE A FORM COMPLETED AND SIGNED BY DOCTOR'S OFFICE.

Has this child had any condition which required emergency treatment or hospitalization? No □ Yes □
If yes, for what? __________________________ At age: ________ How long in hospital? ________
Surgeries (operations)? __________________________

________________________________________

Check off the following health categories/concerns that pertain to your child:

- **Eyes:** wears glasses □ wears contacts □ for reading □ for distance □ all the time □ single vision □

- **Ears:** Frequent infections □ ear tubes present □ since __________________________
Wears hearing aid: right ear □ left ear □ hearing difficulty: explain: __________________________

- **Other:** □ nosebleeds □ requires diapering □ sleeping difficulties □ eating too little
□ bowel □ requires catheterization □ dental concerns □ phobias
□ bladder □ bed wetting □ eating too much □ menstruation

Does this child have any medical, physical, social, or emotional problems that the school should know about? (disabilities; parents recently separated; etc.) __________________________________________

Does any relative or anyone in the home have tuberculosis, diabetes, or other illness?________________________________________
Describe: __________________________________________________________

________________________________________ (Signature of legal parent/guardian) ____________ (Date)

12/16