City of Newton

Setti Warren
Mayor

HEALTH AND HUMAN SERVICES DEPARTMENT
Dori Zaleznik, MD, Commissioner
1000 Commonwealth Ave.
Newton, MA 02459
Telephone 617.796.1420 Fax 617.552.7063
TDD/TTY 617.796.1089

Newton South
Gail Kramer, RN
School Nurse
Phone
617.559.6575
Fax
617.559.6701

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

continued on back

Does your child have any of the following:

Y	N		Y	N	
☐	☐	Seizures	☐	☐	Chicken Pox – Date_____
☐	☐	Heart Issues	☐	☐	Developmental Delay
☐	☐	Diabetes	☐	☐	Psychological Problems
☐	☐	Frequent Headaches/Migraines	☐	☐	Speech Difficulty
☐	☐	Frequent Ear Infections	☐	☐	Vision Difficulty – Glasses { }
☐	☐	Urinary/Kidney Problems	☐	☐	Hearing Difficulty – Hearing Aid { }
☐	☐	Skin Conditions	☐	☐	Sleep Difficulties/Nightmares
☐	☐	Scoliosis	☐	☐	ADD, ADHD
☐	☐	Frequent Nose Bleeds	☐	☐	Behavioral Difficulty
☐	☐	Lactose Intolerance	☐	☐	Other
☐	☐	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.

Signature of Parent **Date of Registration**

Updated August 2010