

GLOVERSVILLE ENLARGED SCHOOL DISTRICT
HEALTH SERVICES

Health Registration Record

School _____ Date _____
Student's Full Name _____ Female _____ Male _____
Student's Birth Date _____ Birthplace _____
Student's Address _____ Telephone _____
Mother's Full Name (include maiden name) _____
Father's Full Name _____
Brothers/Sisters _____ Date of Birth _____

Family Doctor _____ Dentist _____
School last attended _____ Grade _____
Has your child ever attended a Gloversville School? _____ Which school(s)? _____

Immunizations

The following immunizations are required by New York State Law:

DPT – 3 Doses

Polio – 3 Doses

MMR – 2 Doses MMR (measles, mumps, rubella) OR 2 Doses Measles and 1 Dose of Mumps and Rubella

Hep. B – 3 Doses

Varicella – 1 Dose if born on or after 1/1/98

Hib – 3 Doses (Headstart and Pre-K students only)

Please provide proof of all immunizations with a medical certificate from a doctor, health clinic
or previous school records. Failure to provide proof of immunizations within 14 school days may
necessitate exclusion of your child from school.

Student History:

1. Did mother experience any complications during the pregnancy? _____ If yes, please explain
2. Was child full term? _____ If premature, how early? _____
3. Was the child healthy at birth? _____ Birth weight _____ lbs. _____ Oz.
4. Did the child experience any problems at birth?
Please explain _____
5. Did your child have any problems learning to talk, walk or toilet train? Please explain: _____

< **OVER** >

6. Please check if your child had or has any of the following:

COMMENTSADD/ADHD (Diagnosed by a doctor) ()

Allergies***** ()

(Life Threatening allergies must have medical documentation)

Anemia ()
Asthma ()
Bladder/bowel problem ()
Chicken pox ()
Contact with tuberculosis ()
Diabetes ()
Skin problem ()
Frequent ear/hearing problem ()
Frequent headaches ()
Frequent nosebleeds ()
Heart problems ()
Kidney/urinary problem ()
Physical disability ()
Seizure disorder ()
Speech problem ()
Thyroid/growth problem ()
Glasses/vision problem ()
Other ()

7. Current medications your child is taking:

8. Hospitalizations (dates and reasons):

9. Will your child need any modification of school activities? Please explain:

10. Has your child received any specialized medical testing or treatments? _ Please explain:

Family history:

Please indicate any that apply to your immediate family (parent, sister, brother, grandparent, aunt, uncle) (must be diagnosed by a doctor)

ADD/ADHD:

Allergy:

Depression:

Developmental disability:

Diabetes:

Hearing problem:

Heart:

Physical disability:

Seizure disorder:

Scoliosis:

Vision problem:

Signature

(Rev. 3/03)