

NEW STUDENT HEALTH REGISTRATION

Date _____

Name of Student _____ Entering
Grade _____

Address _____
Birthdate _____

Previous Maryland Public School Attended _____ When?

Previous School Attended (Other than a Maryland Public School)

Address _____

Name of Mother _____ Phone: (H) _____ (W)

Name of Father _____ Phone: (H) _____ (W)

Name of person to call if parent(s) cannot be reached in an emergency:

Phone: _____

Has student had any of the following health problems? (Check if YES.)

____ ASTHMA	____ SEIZURE	____ DIABETES
____ ADHD	____ HEART CONDITION	____ SEVERE
____ VISION PROBLEM		
____ CEREBRAL PALSY	____ HEMOPHILIA	____ HEARING
____ PROBLEM		
____ ALLERGIES –		
LIST _____		

Other _____

Is there a health problem that would prevent full participation in the school program or physical education program?

Is there a need for special seating?

Is the student on any long-term medication?

Do you need help in getting health insurance for your child?

Is there a need for you or your child to have a conference with the nurse?

What is the source of household water supply?

_____ CITY

_____ WELL

Guardian

Signature of Parent or Legal

AN IMMUNIZATION CERTIFICATE MUST ACCOMPANY THIS FORM PRIOR TO ENTRY INTO SCHOOL.