

BALTIMORE COUNTY DEPARTMENT OF HEALTH
Division of School Health

New Student Health Registration

Dear Parent or Legal Guardian:

As your child is new to our school, completion of the following questionnaire will be helpful in assuring the best possible adjustment to our program. If a health problem is present, you can readily understand our desire to have this information as soon as possible. This information will be available to appropriate school personnel working with the student and the information will be kept in the student's health record.

Date _____

Name of Student _____ Entering Grade _____

Address _____ Birthdate _____

Previous school attended _____

School Address _____

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

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

Name of person to call in emergency _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsive Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Speech Problem |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hearing Problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Severe Vision Problem |
| <input type="checkbox"/> Other _____ | | |

Is there a 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? _____

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

What type of Health Insurance do you have? Private _____ HMO _____ Medical Assistance _____ None _____

Signature of Parent or Legal Guardian

An Immunization Certificate Must Accompany This Form Prior to Entry Into School