



HEALTH REGISTRATION FORM

Please use black ink and fill this form out completely!

Name: _____ DOB: _____ Grade _____ Gender _____
Last First M I (Legal Name if Different)

Address: _____ Primary Phone: _____
Street City State Zip Code

Is this a new address and/or phone number? _____ Yes _____ No

Student Lives with:	Both Parents	Mother Only	Father Only	Mother & Stepfather	Father & Stepmother
(Circle One)	Agency	Self	Legal Guardian	Other:	

Father's Name: _____ Mother's Name: _____

Father's Work Phone: _____ Mother's Work Phone: _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Doctor: _____ Phone: _____ Preferred Hospital: _____ Default is St. Michael's

Health History:*

Please answer by checking:	No	Yes	Glasses	Contacts	No	Yes	
Does student have vision problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Does student have hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>
Check if student has any of the following:	No	Yes	Mild	Moderate	Severe	Life Threatening	
Anaphylactic Allergy:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problem:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures, type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Explain if other issues exist (including learning disabilities ADHD or ADD):

***If a student has diabetes, a life threatening allergy, or medical condition; state law requires that a care plan be in place. Prior to admission, we will need a medication and/or treatment order signed by a Licensed Health Care Professional and the parent/guardian.**

Does student take medications of any kind?**	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Will student need to take medications at school?**	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list: _____
Has student had any serious injuries?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Explain: _____

*The nurse's office will share serious health information with your student's teacher and other school staff. If you do **NOT** want information shared, please call the school nurse.

Students requiring medication (prescription or non-prescription) at school **MUST have a written order by a **Licensed** Health Care Professional and written **parent** consent. These forms are available at every building from the secretaries and the school nurse.

In the event of a serious accident or injury we will attempt to contact the parent/guardian first. If parents can not be reached I authorize Bremerton School District staff to contact a doctor/dentist or 911, if necessary. I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital.

***911 will be called if deemed necessary**

****IT IS VERY IMPORTANT THAT YOU INFORM THE SCHOOL NURSE OF ANY CHANGES IN YOUR CHILD'S HEALTH THAT MAY OCCUR THROUGHOUT THE SCHOOL YEAR.**

Parent/Guardian Signature: _____ Date: _____