MINERSVILLE AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES

MEDICAL REGISTRATION FORM

DEMOGRAPHIC DATA:

Student's Name: _____ Date of Birth: _____
Grade: _____ Male ☐ Female ☐
Address: _____
Phone: _____ Alt. Phone: _____
Parents/Guardian names: _____ _____
Siblings (names & ages): _____ _____
_____ _____

HEALTH HISTORY:

Child's Doctor: _____ Date of last Dr. Visit: _____
Child's Dentist: _____ Date of last Dental Exam: _____

Medications- List all medications student takes and reason: _____
_____ _____

Note: We encourage all medication to be administered at home. However, if your child will require administration of medications during the school day a parental permission form and original physician's order must be provided to the school nurse.

Allergies: _____ Reaction: _____
Has the child ever required use of an Epi-pen for an allergic reaction: _____

Health Conditions:

Please check below and provide date of diagnosis if your child has any of the following conditions:
ADD/ADHD _____ Arthritis/Joint Problems _____ Asthma _____ Birth Defects _____
Blood Disorder _____ Bowel Problems _____ Cancer _____ Developmental Delays _____
Diabetes _____ Hearing Problems _____ Heart Problems _____ Learning Problems _____
Mental Health Issues _____ Migraines _____ Physical limitations _____ Seizures _____
Skin disorders _____ Stomach/Digestive Problems _____ Urinary issues _____

Other serious health or emotional concerns: _____
History of Hospitalizations: _____

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OTHER CONCERNS:

Please share other information or concerns about your child's emotional, physical, or developmental growth:

_____
_____
_____

Please share any family circumstances or behavioral concerns you may have about your child:

_____
_____
_____

Does your child currently have an IEP or 504 Plan? YES ☐ NO ☐

Parent/Guardian: _____ Relationship: _____
Printed Name

Parent/Guardian: _____ Date: _____
Signature