Please complete both sides and return to school

New registration

2016-2017

(Student Name) (Date of Birth) (Entering Grade)

NEW BOSTON CENTRAL SCHOOL
NEW REGISTRATION HEALTH QUESTIONNAIRE

Judith Limondin, RN School Nurse 487-2211, ext 304

Gender ___M ___F Place of Birth _____
Home Address _____ Phone # _____

Father/Guardian _____ Phone # _____
Address _____ Cell # _____
_____ Business # _____

Mother/Guardian _____ Phone #_____
Address _____ Cell # _____
_____ Business # _____

Parents are ___Married ___Divorced ___Separated ___Widowed
Child resides with _____
Are there any other people living in the home? Please list _____

Does your child have a Primary Care Provider (MD, Nurse Practitioner, Clinic)? ___ yes ___ no
Date of last Physical: _____ Provider's name: _____
Were there any special concerns or recommendations? _____
_____

Written documentation from your provider of up-to-date vaccinations and a recent physical exam are required prior to school entry.

Has your child ever been hospitalized? ___ yes ___ no For what reason? _____
_____
_____
Describe any serious illnesses or accidents your child has had: _____
_____
_____
Does your child have any allergies? ___ yes ___ no Please list:_____
_____
_____
Does your child have an Epi-pen for severe allergic reactions? ___ yes ___ no
Does your child have asthma? ___ yes ___ no If yes, list daily and rescue medications below.
Does your child use a rescue inhaler? ___ yes ___ no

Is your child on any prescription medication? ___ yes ___ no
Please list: Name Dose Time given Reason for taking
_____
_____
_____
_____
_____

For prescription medication to be administered at school, the NH Department of Education requires a signed doctor's order and signed parent request (form available from the School Nurse) and the medication must be in its original prescription bottle, brought to the school by a responsible adult. Please contact the school nurse to make these arrangements.

CHILDREN MAY NOT CARRY ANY MEDICATION TO OR FROM SCHOOL

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Medical concerns, please check all that apply and provide treatment details below:

___Diabetes ___Seizures ___Head Injury ___Heart Problems
___Urinary problems ___Skin problems ___Depression ___Anxiety
___Attention Deficit Disorder ___Frequent Headaches ___Frequent Nosebleeds
___Frequent Ear Infections ___Frequent Stomachaches ___Bowel Problems
___Orthopedic Issues ___ Other

_____
_____
_____
_____
_____

Does your child have a dentist? ___ yes ___ no ___ My child has never seen a dentist.
Date of last dental cleaning/consultation: _____

Every year in early March, students are able to have their teeth cleaned and receive a fluoride treatment by Dr. Brenner at very low cost ($10) or for free if family funds are limited. Transportation is provided during school hours to his office in New Boston. Would you like your child to participate in the dental cleaning program in March? ___ yes ___ no (More information will be sent home prior to the program.)

Do you suspect your child has difficulty hearing? ___ yes ___ no If yes, please describe: _____
_____
If your child has ever had a hearing assessment and/or treatment for a hearing problem, please describe:
_____
Do you suspect your child has a vision problem? ___ yes ___ no If yes, please describe: _____
_____
Has your child ever had a vision exam? ___ yes ___ no If yes, please describe findings: _____
_____
Does your child wear glasses? ___ yes ___ no
Is your child generally able to separate from you without difficulty? ___ yes ___ no
Does your child's activity level seem appropriate for a child her/his age? ___ yes ___ no
Please describe any behavior problems your child experiences (tantrums, hitting, crying easily).
_____
Describe any physical limitations your child has and any modification or restriction necessary to accommodate your child's health or safety: _____
_____
_____
Please supply any additional information you feel would be helpful.
_____
_____

I understand that under the NH Department of Education administrative rule Ed 311.02, all children, prior to entering public school, shall produce documentation of immunization in accordance with the requirements adopted by the NH Commissioner of Health and Human Services. Further, Ed 311.03 requires documentation of a complete physical exam within the year prior to the date of entry into the public school system.

Parent/guardian signature: _____ Date: _____