Rochester City School District

Student Health Services Information

Parent or Guardian please fill as part of your child's registration packet
The following information is needed to complete your child's Health Record.

M ☐ F ☐

Student's Legal Name | Date of Birth | Grade/HR | Sex

Primary Address | Zip Code

Home Phone

Mother/Guardian Name | Cell Phone | Place of Work | Work Phone

Father/Guardian Name | Cell Phone | Place of Work | Work Phone

Phone number where you can be reached during school hours: _____

With whom does your child live? Both parents ☐ Guardian ☐ Mother ☐ Father ☐ Stepparent ☐ Other ☐

Doctor's Name | Phone Number

Does the Child Have Medical Insurance: Yes: ☐ No: ☐ Insurer: _____

Person to contact in case of emergency:

Name | Relationship | Phone Number

Please provide the year that your child has had any disease or condition listed:

Diseases

Chicken Pox _____

German Measles _____

Measles _____

Mumps _____

Rheumatic Fever _____

Scarlet Fever _____

Strep Throat _____

Tuberculosis (TB) _____

TB in Associates _____

Other _____

Lead
High Lead Levels _____

If your child has any life threatening conditions, please explain on the back of this page. The NURSE at your child's school will talk to you about this.

Conditions

Accident, Injury, Hospital _____

Attention Deficit Disorder _____

Allergy to (list):

Food _____

Insect _____

Medicine _____

Life-threatening: Yes ☐ No ☐

If yes, are medications needed for

School? Yes ☐ No ☐

Asthma _____

Arthritis _____

Autistic Spectrum Disorder _____

Behavioral Problem _____

Blood Disorder _____

Convulsions or Neurological Disorder ____

Chronic Illness _____

Dental Problems _____

Diabetes _____

Ear Problems _____

Eye Problems:

Corrective Lenses Yes ___ No___
Are lenses impact-resistant? Yes ___ No___
When should glasses be worn?
Board work: Yes ___ No___
Paperwork: Yes ___ No___
Phys. Ed. / Sports: Yes ___ No___
All the time: Yes ___ No___
Loss of vision in one eye: Yes ___ No___
Visually impaired: Yes ___ No___

Hernia _____ *Repaired* _____

Heart Defect _____

High Blood Pressure _____

Language/Speech Disorder _____

Learning Disability _____

Loss/Impairment of one of paired organs: (kidney, testicle) _____

Mental Health Diagnosis _____

Orthopedic Problems _____

Scoliosis _____

Current Prescribed Medications:
Daily ____ *As needed* ____

Reason _____

_____

_____

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TO BE COMPLETED BY PARENT OR GUARDIAN

My child has one of the following life-threatening conditions and will need an emergency care plan completed by the school nurse and myself with written guidance from our private physician. I understand that it is my responsibility to provide physician orders and any prescribed life saving medication to the school nurse. I understand that if my child needs to carry life saving medications, I must receive prior administrative approval and must provide a second dose in the school health office in the event my child misplaces the life saving medicine.

_____

Student's Legal Name

Please Specify:

Life-threatening allergy: Food ☐ Insect ☐ Medicine ☐ _____

Asthma _____

Diabetes _____

Poorly controlled seizures _____

Severe swallowing problems or choking _____

Significant heart disease _____

Other _____