

KETTERING CITY SCHOOL DISTRICT

HEALTH INFORMATION REGISTRATION FORM

Dear Parent,

Please complete the following health questionnaire regarding your child. The information will be reviewed by the school nurse and shared with school personnel as necessary.

Date: _____ Unit: _____ Grade/Teacher: _____

Student name: _____ (I.D. # _____)

1. Does your child have a chronic health problem? Yes _____ No _____

If yes, describe _____

2. Does your child take medication? Yes _____ No _____

If yes, what is the medication? _____

Will he/she need to take it during school hours? Yes _____ No _____
(IF YES, PLEASE REQUEST A PERMISSION TO ADMINISTER MEDICATION FORM)

3. Does your child have food, inhalant or stinging insect allergies? Yes _____ No _____

If yes, please describe reaction _____

4. Does your child wear glasses? Yes _____ No _____ Contacts? Yes _____ No _____

5. Does your child wear a hearing aid? Yes _____ No _____

6. Please list any other health history or medical information that school personnel should be aware of:

Signature of Parent/Guardian

Daytime Phone Number

Thank you for helping us make school a safe and healthy place for your child!