BALTIMORE COUNTY PUBLIC SCHOOLS
Towson, Maryland 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
Towson, Maryland 21204

NEW STUDENT HEALTH REGISTRATION

Date_____

Name of Student_____ Entering Grade_____

Address_____ Birthdate_____

Previous School Attended_____

Address_____

Name of Mother_____ Phone: (H)_____ (W) _____

Name of Father_____ Phone: (H)_____ (W) _____

Name of person to call if parent(s) cannot be reached in an emergency:

_____ Phone:_____

Has student had any of the following health problems? (Check if yes.)

____Asthma	____Seizure	____Diabetes
____ADHD	____Heart Condition	____Severe Vision Problem
____Cerebral Palsy	____Hemophilia	____Hearing Problem

____Allergies–List:_____

____Other–List:_____

Is there a health problem that would prevent full participation in the school program or physical education program?

_____

Is there a need for special seating? _____

Is the student on any long-term medication?_____ _____

Do you need help in getting health insurance for your child? _____

Is there a need for you or your child to have a conference with the nurse?_____

What is the source of household water supply? _____City _____Well

_____
Signature of Parent or Legal Guardian

AN IMMUNIZATION CERTIFICATE MUST ACCOMPANY THIS FORM PRIOR TO ENTRY INTO SCHOOL.

Birth History:
List any:

Difficulties during pregnancy: _____
Medications taken during pregnancy: _____
Complication after delivery: _____
Birth defects: _____
Childhood milestones delayed or met with difficulty: _____

Check:
Birth: Natural_____ C.Section_____ Full Term_____ Early_____ Late_____

Hearing/Vision Problems:
_____Glasses _____Contacts _____Hearing aid

Allergies:
Food_____ Medicine_____ Bee Stings_____
Details: _____
Has your child ever been stung by a bee? _____

Suffers from frequent:
Colds_____ earaches_____ sore throats/strep_____

List any **medications** your child is presently taking and why:_____
_____

****Medication Policy****

We attempt to discourage administration of medication in school. If for any reason it becomes necessary for your child to be given medication while in school, **a written order** from the physician must be given to the nurse along with the medication. Children are **not permitted** to take medication on their own. **Parents must** sign permission forms for the school to administer medication while in school.

It is recommended that the first dose of medication be administered at home.

Bring the medication to the school in the original or a duplicate box or bottle with the current prescription label on the container. Upon request, pharmacists have labeled empty containers to be used.

I HAVE READ AND UNDERSTAND THE MEDICATION POLICY.

_____ _____ _____
Signature of Parent/Guardian Relationship to Student Date