

**Spencer-Van Etten Central School District  
Health Registration  
Student Information**

Student Name		Date of Birth:	Male / Female	
Transferring from Another State: Yes / No	If yes, what state:	Previous School & Address:  Phone: (      )		
Date of Last Physical:	School MD _____  Private MD _____	If Private MD Physician Name :  Physician Phone: (      )	Date of Last Dental Exam:	Dentist:

**Medical History**

**Diseases/Diagnosis:** Please check any diseases/diagnosis student has had. Note date when applicable.

Disease/Diagnosis	Child has had	Date	Disease/Diagnosis	Child has had
Chicken Pox	Yes / No		Heart Disease / Murmur	Yes / No
Mononucleosis	Yes / No		Asthma	Yes / No
Pneumonia	Yes / No		Diabetes	Yes / No
Seizures	Yes / No	Last Seizure:	Frequent Colds	Yes / No
Concussion	Yes / No	Last Concussion:	Ear Infections	Yes / No
Allergies	Yes / No	Type: (food, medicine, bees, etc)		
Bone Disorders / Injuries	Yes / No	Describe:		

**Serious Injuries / Surgery / Illness:** Please list any serious injuries, operations, or illnesses student has had, including any concussions.

Injury / Surgery / Illness	Date	Please Describe

**Medications:** Please list any medications student is taking:

Medication	Dose	When Given	Comments

**Limitations:** Are there any limitations the student has because of health problems/conditions?

<p>Limitations:</p>  <p>Any other medical concerns not mentioned above that we should be aware of in order to give proper care, please describe below:</p>
--

Student wears glasses    yes / no	If yes, for what condition?
-----------------------------------	-----------------------------

Preferred Hospital: \_\_\_\_\_

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_