



# Scituate Public Schools

Scituate, Massachusetts 02066

## KINDERGARTEN REGISTRATION HEALTH INFORMATION / HISTORY

**Student Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** (where parent can be reached during the day) \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

**Legal Guardian's Name:** \_\_\_\_\_

**Emergency Contact** (other than parent) – someone to dismiss your child should we not be able to reach you:

**Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

In order to properly care for the health of your child while he/she is in school, please provide the following medical information. Please **circle** any of the following that your child has/had. Give date or age (if applicable)

- |                          |                            |                          |
|--------------------------|----------------------------|--------------------------|
| ADHD                     | Headaches                  | Sleep Problems           |
| Allergies (list on back) | Hearing Problems           | Thyroid Disease          |
| Anemia                   | Heart Problems             | Urinary Tract Infections |
| Asthma                   | Intestinal/Stomach Trouble | Other Health Problems    |
| Cancer                   | Operations                 |                          |
| Constipation             | Pneumonia                  |                          |
| Convulsions/Seizures     | Psychological Problems     |                          |
| Diabetes                 | Rheumatic Fever            |                          |
| Disability               | Scarlet Fever              |                          |
| Ear Problems             | Sinus Trouble              |                          |
| Head Injury              | Skin Problems; Eczema      |                          |

My child is currently taking the following medication. Please list all medications your child is currently taking including those to be given during the school day:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Over**

**I give permission for the School Nurse or designated school personnel, in accordance with the Massachusetts Department of Public Health, to administer the following medications in accordance with the standing doctor's order for the Scituate Public Schools prescribed by Dr. Stephen Lane, M.D. (School Physician)**

\_\_\_\_ Sterile Eye Drops

\_\_\_\_ Antibiotic Ointment

\_\_\_\_ Mylanta/Maalox

\_\_\_\_ Throat Lozenge

\_\_\_\_ Ibuprofen (weight appropriate dose)

\_\_\_\_ Rhuli Gel/Calamine

\_\_\_\_ Tylenol (weight appropriate dose)

\_\_\_\_ Petroleum Jelly

\_\_\_\_ Benadryl (allergic reactions)

\_\_\_\_ **All of the Above**

\_\_\_\_ **None of the Above**

**Signature of Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_