ELEMENTARY HEALTH ENROLLMENT FORM (B)

Child's Name: ____ Date of Birth: _____________

	(please check) YES	NO
• Has your child ever attended a Boise School?	☐	☐
• Copy of immunization record provided to this school? (*Parent/Guardian must provide copy prior to attendance.)*	☐	☐
• Has your child had the Chicken Pox disease?	☐	☐
• Does your child have any **ALLERGIES**? If yes, what kind: ______________________	☐	☐
• Is your child on any **MEDICATION**? If yes, please list current medications: ____	☐	☐
• **Will it be necessary to take medication at school? (please see nurse)**	☐	☐
• **VISION:** Has your child had their eyes checked by a doctor in the last year?	☐	☐
Does your child wear glasses ___ contact lenses ___?	☐	☐
• **DENTAL:** Has your child seen a dentist in the last year?	☐	☐
HEALTH HISTORY:		
• Has your child had a history of chronic ear infections?	☐	☐
Does your child currently have tubes in their ears?	☐	☐
Does your child have a hearing loss?	☐	☐
• Has your child had any surgeries?	☐	☐

If yes, please explain: ____

• Does your child have any **specific medical problems or physically limiting disorders** we should know about? If yes, please explain: ____ ☐ ☐

____

• Were there any problems with pregnancy, labor, birth or shortly thereafter? ☐ ☐

If yes, please explain: ____

____

• Was your child born prematurely? Birth Weight___________ ☐ ☐

• Has your child had any serious childhood illnesses, accidents or concussions? ☐ ☐

If yes, please explain: ____

____

• Do you have any concerns about **learning problems, speech and/or language problems, short attention span or hyperactivity?** ☐ ☐

If yes, please explain: ____

If short attention span or hyperactivity, what age did it first occur? __________________________

• What major changes or events in your family situation occurred during the last year?

☐ moving ☐ death of family member ☐ divorce ☐ serious illness or accident of family member

☐ other ____

• People living in home:

Name	Age	Relationship

The above information may be shared with school personnel only when needed to assist with your child's education or safety.

Parent's Signature: ____Date: ________________

(OVER)

02/06
Reviewed 08/10

I *WILL ALLOW* the school nurse and/or authorized personnel to give my child Ibuprofen, Acetaminophen, cough drops or antacids at school for minor problems. (Complaints of headache, pain due to musculoskeletal injury, orthodontic procedures, and/or menstrual cramps, dry throat, and upset stomach and/or indigestion.)

*Parents may be asked to consult a physician if their child makes frequent requests for medications (such as three times a week for a two-week period of time.)
This information may be shared with school personnel on a need to know basis.

Parent Signature: ______________________________ Date: __________________