

Broad Brook Elementary School
Kindergarten Registration
2017-2018
Medical Screening

Student's Name: _____ Date of Birth: _____

Parent Name: _____ Phone: _____

Address: _____

Physician's Name: _____ Phone: _____

Please circle all health issues listed below that apply to your child:

Hearing problem/hearing aid	GERD/reflux	
Vision problem/glasses/contacts	ADHD/ADD	Diabetes
Asthma	Sickle Cell Trait	Scoliosis
Cancer	Cerebral Palsy	Kidney
Depression	Autism/Asperger's	Heart problems
Anxiety	Lyme Disease	High blood pressure
Nutritional/weight issues	Migraines	Seizures
PDD/NOS	OCD	PTSD

Please explain any items that you may have circled: _____

Does your child have any allergies? (ie food, insects, latex, or medications):

Will your child need prescription medication at school? Yes or No (circle one)

Please specify: _____

Does your child take prescription medication at home?

Students with a life-threatening allergy must have an Epipen at school. Students who have asthma and use a rescue inhaler at home are encouraged to have an inhaler at school.

Parent Signature: _____ Date: _____

