Broad Brook Elementary School
Pre-Kindergarten Registration
2018-2019
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? (i.e. 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 required to have an inhaler at school.

Parent Signature: __________________________________ Date: _______________________