PLEASE USE BLACK INK AND FILL FORM OUT COMPLETELY
DAVENPORT SCHOOL DISTRICT – HEALTH REGISTRATION FORM

STUDENT NAME: _____ **BIRTHDATE** _____
Last First M.I.

ADDRESS: _____ _____ _____ **HOME PHONE**: _____
Street City Zip Code

Student Lives with: Both Parents Mother Only Father Only Mother & Stepfather Father & Stepmother
(CIRCLE ONE) Agency Self Legal Guardian Other: _____

Father's Name: _____ Mother's Name: _____

Father's Work Phone: _____ Mother's Work Phone _____

Father's Cell Phone: _____ Mother's Cell Phone: _____

Emergency Contact Name: _____ Relationship to Child: _____ Phone: _____

Emergency Contact Name: _____ Relationship to Child: _____ Phone: _____

Medical Insurance Co: _____ Policy #: _____ Preferred Hospital: _____

Doctor: _____ Phone: _____ Dentist: _____ Phone: _____

HEALTH HISTORY *: Please answer by checking box

	No	Yes	Glasses	Contacts	No	Yes	Hearing Aid
Does student have vision problem?	☐	☐	☐	☐	**Does student have hearing problem?**	☐	☐	☐

Check YES or NO on all categories:	No	Yes	Mild	Moderate	Severe	Life Threatening
Anaphylactic Allergy: _____	☐	☐	☐	☐	☐	☐
Allergies to: _____	☐	☐	☐	☐	☐	☐
Asthma _____	☐	☐	☐	☐	☐	☐
Diabetes _____	☐	☐	☐	☐	☐	☐
Heart Problem _____	☐	☐	☐	☐	☐	☐
Seizures, type: _____	☐	☐	☐	☐	☐	☐

Has your child ever had chicken pox? ☐ ☐ **If yes, approximate age** _____

Explain if other issues exist (including learning disabilities, ADHD or ADD): _____

_____

IF student has diabetes*, a life threatening allergy, or medical condition, state law requires that a care plan be in place, please contact Cindy Hansen, RN, School Nurse, at 509-725-1261.
We will need a medication and/or treatment order signed by the Licensed Health Care Professional and the Parent/Guardian.
We need this at school PRIOR to admission.

Does the student take medication of any kind? NO ☐ YES ☐ If yes, list: _____

Will student need to take medications at school?** NO ☐ YES ☐ IF yes, list: _____

Has student had any serious injuries? NO ☐ YES ☐ If yes, explain: _____

***The nurse's office will share health information with your student's teacher and other school staff. IF you do not want information shared, please call Cindy Hansen, RN Davenport School Nurse at 509-725-1261.**

Students** requiring medication (prescription or non-prescription) at school **MUST** have a **Medication Request Form** signed by a parent/guardian **and** a Licensed Health Care Provider. These forms are available in every building office and from the school nurse.

In the event of a serious accident or injury we will attempt to contact the parent/guardian first. If parent/guardian cannot be reached I authorize the Davenport School District staff to contact a doctor/dentist or 911*, if necessary and I further authorize those contacted to initiate necessary treatment for emergency care, including transportation to the hospital. *911 WILL BE CALLED IF DEEMED NECESSARY

****IT IS VERY IMPORTANT THAT YOU INFORM THE SCHOOOL NURSE OF ANY CHANGES IN YOUR CHILD'S HEALTH THAT MAY OCCUR THROUGHOUT THE SCHOOL YEAR**.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____