MIDDLE COUNTRY CENTRAL SCHOOL DISTRICT **ATTN: SCHOOL HEALTH OFFICE**

DEAR PARENT;

WHEN YOUR CHILD ENTERS SCHOOL WE ESTABLISH A CUMULATIVE RECORD FILE ON HIM/HER TO ENABLE US TO HAVE A GREATER UNDERSTANDING OF YOUR CHILD'S NEEDS. ALL INFORMATION, OF COURSE, WILL BE KEPT STRICTLY CONFIDENTIAL, SO PLEASE ANSWER EVERY QUESTION, PLEASE PRINT NEATLY. THANK YOU FOR YOUR COOPERATION.

STUDENT'S
NAME____ SEX_______ DOB______________ SCHOOL_________

ADDRESS____ PHONE NO.____________________

FATHER/GUARDIAN NAME____ CELL PHONE NO.___________________

MOTHER/GUARDIAN NAME____ CELL PHONE NO.___________________

PARENT'S PLACE OF EMPLOYMENT
FATHER/GUARDIAN____ WORK NO._____________________

MOTHER/GUARDIAN____ WORK NO._____________________

PHYSICIAN TO BE CALLED IN EMERGENCY (LOCAL) PHONE NO.________________________________

TRANSPORTATION OF AN ILL CHILD IS TO BE ARRANGED BY PARENT OR PERSONS NAMED ABOVE
IT IS A PARENTAL RESPONSIBILITY TO NOTIFY THE SCHOOL NURSE OF CHANGES IN THE ABOVE.

FOR OFFICE USE ONLY:

_____ IMMUNIZATION RECORD VERIFIED/ATTACHED

Initials of Central Registration staff member_____________

TO BE COMPLETED BY PARENT. PLEASE INDICATE IF HISTORY AND DESCRIBE BELOW:

ANEMIA_________ ASTHMA__________ ALLERGIES_________ DIABETES_________ EPILEPSY____________________
HEART DISEASE___________KIDNEY DISEASE________ TUBERCULOSIS OR CONTACT WITH TB______________
SERIOUS ILLNESS, INJURY, OPERATIONS____
EXPLANATION OF ABOVE AS CHECKED:____

____

IS MEDICATION GIVEN ON A REGULAR BASIS? NO______ YES______
WILL MEDICATION BE GIVEN DURING SCHOOL? NO______ YES______

NEW YORK STATE LAW REQUIRES THE PARENT TO SUBMIT A WRITTEN REQUEST TO THE SCHOOL, AND IT MUST BE ACCOMPANID BY A WRITTEN REQUEST FROM THE PHYSICIAN, IN WHICH HE INDICATES THE FREQUENCY AND THE DOSAGE OF THE PRESCRIBED MEDICATION.
THIS MEDICATION MUST BE BROUGHT IN BY THE PARENT IN A PRESCRIPTION BOTTLE.

ANY VISION PROBLEMS: NO______ YES______ PLEASE SPECIFY________________________
GLASSES WORN NO______ YES______ DATE OF EXAMINATION___________________
DR./EXAMINER'S NAME/ADDRESS____

HEARING DIFFICULTIES NO______ YES______ HEARING AID WORN NO______ YES______
PLEASE SPECIFY:

DATE OF LAST EXAMINATION____
DOCTOR'S NAME____
ADDRESS

IF ANY MODIFICATION IN THE SCHOOL'S PROGRAM IS REQUIRED, PLEASE SUBMIT A DOCTOR'S WRITTEN RECOMMENDATION.

SIGNATURE OF PARENT/GUARDIAN______________________________________

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