

City of Newton



Setti D. Warren  
Mayor

HEALTH AND HUMAN SERVICES DEPARTMENT

Deborah C. Youngblood, PhD, Commissioner

1000 Commonwealth Avenue  
Newton, MA 02459-1544

Telephone 617.796.1420 Fax 617.552.7063  
TDD/TTY 617.796.1089



Public Health  
Prevent. Promote. Protect.

**STUDENT MEDICAL REGISTRATION FORM ~ TO BE COMPLETED BY PARENT**

Child's Name \_\_\_\_\_ Sex: M { } F { } Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Primary Language \_\_\_\_\_ School \_\_\_\_\_

Siblings (names and ages) \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home Address (if different) \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Name and Address of previous school attended \_\_\_\_\_

Physician's Name and address \_\_\_\_\_ Phone \_\_\_\_\_

Do you currently have health insurance? Yes { } No { } Name of Insurer \_\_\_\_\_

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Pre-Natal History

Pregnancy, Birth, Early Infancy: Were there any problems that you think might be pertinent to your child's growth and development? \_\_\_\_\_

Health History

Does your child have:

Y N

- Completed Immunizations - **Attach complete immunization record**
- Lead screening test- Included in physical examination record – Kindergarten only
- Allergies to food – describe \_\_\_\_\_
- Allergies to medication – describe \_\_\_\_\_
- Allergies to other – describe \_\_\_\_\_

Does your child need treatment for these allergies? Yes { } No { } Explain: \_\_\_\_\_

History of Anaphylaxis EpiPen® Yes { } No { }

Asthma/Reactive airway disease - List triggers: \_\_\_\_\_

What is the current treatment plan? \_\_\_\_\_

Attach *Massachusetts Asthma Action Plan* if available

continued on back

Does your child have any of the following:

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox – Date_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Issues	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Delay
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Problems
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Speech Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Vision Difficulty – Glasses { }
<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Difficulty – Hearing Aid { }
<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Difficulties/Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	ADD, ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Lactose Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal Problems - Constipation { }			

If yes to any of above, describe fully: \_\_\_\_\_  
\_\_\_\_\_

Medications

List all medications your child is taking:

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) taken \_\_\_\_\_  
Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) taken \_\_\_\_\_  
Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) taken \_\_\_\_\_

Circle medications to be administered during school.

**A separate Medication Permission Form is needed for each medication. ([newtonma.gov/medicationform](http://newtonma.gov/medicationform))**

Behavioral/Coping History

Is there any information that would be useful for the staff to help your child at school? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family History

Are there any family situations or health conditions that could have an effect on your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**A physical examination and immunization record by a health care provider is required for all kindergarten, sixth grade and newly enrolled students. Evidence of a lead-screening test is required for all students entering kindergarten.**