GEORGE M. DAVIS JR. ELEMENTARY SCHOOL
80 ISELIN DRIVE
NEW ROCHELLE, NEW YORK 10804

BRIAN OSBORNE, ED.D.
SUPERINTENDENT OF SCHOOLS

ANTHONY BAMBROLA
PRINCIPAL

MAGDA PARVEY, ED.D.
ASSISTANT SUPERINTENDENT AND CHIEF ACADEMIC OFFICER

LAURIE MARINARO
ASSISTANT PRINCIPAL

PHONE 914-576-4421
FAX 914-576-4225

February 1, 2018

Families of Incoming Davis Kindergarten Students:

Kindergarten registration at Davis School will be completed in March of 2018 between March 6th and March 29th. **Student interviews/evaluations will take place during these March registration dates.**

Beginning **February 26th**, you may call our main office @ (914) 576-4421 to schedule an appointment for registration. It is only necessary for one parent/guardian to attend this session. Children **will** attend the registration appointment, as children will be assessed by our kindergarten staff, while the attending parent will meet with our office and clinical staff.

During the initial registration, main office staff will collect forms and check residency. You will also meet with our school nurse, Ms. Nancy Pritz and our social worker, Ms. Heather Cayanan. The entire process should take 30-60 minutes.

In order to speed the registration process and help us stick to our schedule, please complete all registration forms BEFORE arriving at school for your registration appointment. Registration forms can be downloaded off our school website–http://davis.nred.org.

At the time of initial registration, you will need to present the following in order to establish residency and eligibility:

- Your child's original birth certificate (or a certified copy) or passport
- Your child's immunizations records (vaccinations/shots)
- Three (3) proofs of residence (utility bill, phone bill, water bill, tax bill, lease agreement, etc.) showing name and address
- Photo I.D. of parent/guardian

Along with the co-Presidents of the Davis PTA and our Kindergarten teachers, I'm thrilled to invite your family to attend an orientation meeting on **Wednesday, April 18th** at **9:30 a.m.** in order to learn about our Kindergarten programs and the registration process in general. Our teachers will provide a quick overview of their work, and we will offer a student-led, guided walking tour of the school, as well.

If you know of other families joining Davis in Fall 2018, please remind them to engage with our office team to set up their appointment!

For years, Davis Elementary has proudly cherished each of our students and worked to adapt our instruction to meet every child's individual needs and strengths. Our teachers and staff care deeply about our school and their work. We look forward to meeting another group of eager kindergarteners shortly, and look forward to welcoming your family into our school community.

Sincerely,

Anthony Bambrola

Anthony Bambrola

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February 1, 2018

To the Family of _____:

Welcome to Davis! Thank you for scheduling a registration appointment for your child. Your registration appointment has been scheduled for: _____

Please complete all the enclosed forms **PRIOR** to your appointment, so as to help us maintain an efficient and timely process each day. Also remember that at the time of initial registration, you will need to present the following in order to establish residency and eligibility:

- Your child's original birth certificate (or a certified copy) or passport
- Your child's immunizations records (vaccinations/shots)
- Three (3) proofs of residence (a utility bill, phone bill, water bill, tax bill, lease agreement, etc.) showing name and address
- Photo I.D. of parent/guardian

If a question concerning your residence arises, the School District will ask you to provide additional documentation of your residence. If, after supplying such evidence, verification remains unresolved, the School District will conduct a formal investigation into your residency. The District may ask you to provide further proof of residency, including the name and address of your employer, and/or may ask that you attend a conference. During such a conference, a District representative will present you with the evidence we have collected regarding your residency, and you will be given an opportunity to respond.

After the conference, the School District will reach its determination as to your actual residence. If our investigation reveals that you are not a District resident and that you have not relinquished custody and control of your child to a New Rochelle resident, your child will not be permitted to enroll in New Rochelle schools.

Please sign (below) to affirm that you have read and understand our residency requirements and processes outlined in this letter, and to affirm that your children are indeed residents of the City School District of New Rochelle.

Sincerely,

Anthony Bambrola

Anthony Bambrola
Principal

Student's Name: _____

Parent/Guardian's Signature: _____

Date: _____

FOR OFFICE USE ONLY: Birth Cert._____ Res._____ Medical forms____ Lang. Survey____ Transportation_____ M ☐ F ☐
ID#_____CENSUS#_____
Magnet Yes☐ No☐ District-wide Special Education: Yes☐ No☐ Verified by: _____

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM

GEORGE M. DAVIS ELEMENTARY SCHOOL

Registration Information

Only students whose parents or legal guardians reside in New Rochelle may be registered in our district schools. Students attend school according to their area of residence, except in the cast of Magnet students. Proofs of residence must be provided in accordance with district policy. If the person registering the child is not listed as the parent, he/she must provide a copy of the following at time of registration: Court Order naming "Parent by Adoption" or "Legal Guardian" or "Order of Custody."

PLEASE PRINT: Today's Date: _____

Child's Name:_____Date of Birth:_____Male☐ Female☐
City and Country of Birth:_____Cultural Ethnicity (optional)_____
Did Child attend school outside of U.S: Yes☐ No☐ If yes, which _____
Grade(s) attended: Language(s) Spoken at Home:

Child's Current Grade:___Last Grade Attended:___When? _____
Name of Last School: _____
Address of Last School: _____
Telephone Number of Last School:_____Name of Contact Person: _____
Has this child attended school in New Rochelle: When? Where?

Home Address: _____ _____ _____ _____
Street City State Zip Code
Home Telephone Number (s):_____

Father's Name:_____Birthplace:_____
Home Address: _____ _____ _____ _____
Street City State Zip Code

Email address: _____
Telephone Numbers Home:_____Work:_____Cell: _____
Occupation:_____Employer: _____
Marital Status (Please Check One) Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Mother's Name (First and Maiden):_____Birthplace:_____
Home Address: _____ _____ _____ _____
Street City State Zip Code

Email address: _____
Telephone Numbers Home:_____Work:_____Cell: _____
Occupation:_____Employer: _____
Marital Status (Please Check One) Single☐ Married☐ Separated☐ Divorced☐ Widowed☐

Guardian/Custodian Name (other than parent):_____
Home Address: _____ _____ _____ _____
Street City State Zip Code

Relationship to Student:_____Email address: _____
Telephone Numbers Home:_____Work:_____Cell: _____
Occupation:_____Employer: _____

(Please continue to page 2)

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM

DAVIS ELEMENTARY

List below the **FULL** names of all other children in the family				
Name	**Age**	**Date of Birth**	**School Child attends**	**Grade**

Previous Home Address: _____ _____ _____ _____

Street City State Zip Code

Country if other than U.S. **Previous Home Telephone Number:**

Does your child have an I.E.P. from Special Education? Yes☐ No☐

Please list where and when your child has attended school:		
Grade	**School Attended/Location**	**Date of Attendance**
Preschool		
Kindergarten		
Grade 1		
Grade 2		
Grade 3		
Grade 4		
Grade 5		
Grade 6		
Grade 7		
Grade 8		
Grade 9		
Grade 10		
Grade 11		
Grade 12		

Support Services	**Check all that apply**	**Grade(s) in which Services were Received**
English as a Second Language	☐	
Bilingual Class	☐	
Reading Help/Lab	☐	
Resource Room	☐	
Speech/Language	☐	
PT/OT	☐	
Special Education	☐	
Counseling/Social Skills Group	☐	
Repeated a Grade	☐	
Recommended to Repeat a Grade	☐	
Other: (explain)	☐	

Optional – Please check appropriate box(es)		
Father		**Mother**
☐	American Indian/Alaska	☐
☐	Asian	☐
☐	Black/African American	☐
☐	Hispanic or Latino	☐
☐	Multiracial	☐
☐	Native Hawaiian/Pac. Isl.	☐
☐	White	☐

(Please continue to page 3)

CITY SCHOOL DISTRICT OF NEW ROCHELLE REGISTRATION FORM
DAVIS ELEMENTARY

Child's Name:_____

Emergency Contact: _____

Relationship to Child: _____

Parent/Guardian:_____

Telephone Numbers Home:_____Work:_____Cell: _____

Other Designated Adult (Include Relationship to child):_____

Telephone Numbers Home:_____Work:_____Cell: _____

PLEASE NOTE:

IT IS IMPORTANT FOR YOU TO PROVIDE THE SCHOOL WITH YOUR CURRENT PHONE NUMBERS IN ORDER THAT YOU CAN BE REACHED IN THE EVENT OF AN EMERGENCY. *PLEASE NOTIFY THE SCHOOL WITH ANY CHANGES TO YOUR CONTACT INFORMATION, I.E., CHANGES TO PHONE NUMBERS, ADDRESS CHANGE, EMERGENCY CONTACT NAMES, ETC.*

SIGN FORM IN PRESENCE OF SCHOOL PERSONNEL AT THE SCHOOL REGISTRATION:

_____

Print Name of Parent or Guardian Completing Form

_____

Signature of Parent or Guardian Completing Form

_____

Today's Date

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH: *Month* *Day* *Year*

GENDER: ☐ Male ☐ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	☐ English	☐ Other _____ *specify*	
2. What was the first language your child learned?	☐ English	☐ Other _____ *specify*	
3. What is the Home Language of each parent/guardian?	☐ Mother _____ *specify*	☐ Father _____ *specify*	☐ Guardian(s) _____ *specify*
4. What language(s) does your child understand?	☐ English	☐ Other _____ *specify*	
5. What language(s) does your child speak?	☐ English	☐ Other _____ *specify*	☐ Does not speak
6. What language(s) does your child read?	☐ English	☐ Other _____ *specify*	☐ Does not read
7. What language(s) does your child write?	☐ English	☐ Other _____ *specify*	☐ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** *No* *Not sure*
☐ ☐ ☐ *If yes, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ☐ No ☐ Yes* *Please complete 10b below*

10b. *If referred for an evaluation, has your child ever *received* any special education services in the past?
☐ No ☐ Yes – Type of services received:_____

Age at which services received *(Please check all that apply)*
☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

10c. Does your child have an Individualized Education Program (IEP)? ☐ No ☐ Yes

11. Is there anything else you think is important for the school to know about your child? *(e.g. special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year:
Signature of Parent or of Person in Parental Relation *Date*

Relationship to student: ☐ Mother ☐ Father ☐ Other:_____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ☐ NO ☐ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR)

OUTCOME OF INDIVIDUAL INTERVIEW:
☐ ADMINISTER NYSITELL
☐ ENGLISH PROFICIENT
☐ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO DAY YR)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL:
☐ ENTERING ☐ EMERGING ☐ TRANSITIONING ☐ EXPANDING ☐ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

NEW ROCHELLE CITY SCHOOL DISTRICT
Office of Transportation
515 North Avenue, New Rochelle, NY 10801

AM BUS: _____ **TIME:** _____ **AM STOP:** _____

PM BUS: _____ **TIME:** _____ **PM STOP:** _____

BUS COMPANY: _____ **START DATE:** _____

Parent/Guardian: *Complete one application for each student being registered. The transportation office staff will identify and notify students by mail at the end of August those who meet the 1.5 mileage requirement necessary to receive bussing.*

2018-2019 Transportation Application
New Rochelle Public Elementary Schools

1. New Student:_____ **2.** Address Change:_____ **3.** School Change:_____

4. Magnet CILA (circle one) Kaleidoscope Previous School

School: _____ Grade (circle one): PA PP K 01 02 03 04 05

Student ID#: (REQUIRED)_____ Today's Date: _____

STUDENT DATA INFORMATION

Student Name:_____
LAST Name FIRST Name Middle

Student **Home** Address:

Street:_____ Apt No.:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Sex:_____

Parent *OR* Legal/Custodial Guardian Information

Title: (circle) **Dr. Mr. Mrs. Ms. Mr. & Mrs.** (print) **Other**_____

Mother_____ Father_____
Last name First name Last name First name

Primary Phone# _____ Mother Cell# _____ Father Cell# _____

E-Mail _____

Signature of Mother or Father or Legal/Custodial Guardian_____ **Relationship to Student:**_____
(mother, father, other)

Emergency Contact (other than parent or legal/custodial guardian)

Mother_____ Phone #_____

Revised 2-4-15

Dr. Brian Osborne, Superintendent of Schools
Dr. Magda Parvey, Assistant Superintendent

City School District of New Rochelle
Dismissal and Contact Form
Despido y Contacto

2017-2018

Please Print

ID:

Student's Name / *Nombre del estudiante*	Date of Birth/ *fecha de nacimiento*	Teacher/ *Maestro(a)*

Home Address / *dirección*	City / *ciudad*	State / *estado*	Zip / código de zip

Emergency Early Dismissal / Despido de Emergencia

In the event of an early dismissal due to an emergency (weather, etc.), please indicate how you child should go home.
En caso de que las escuelas despachen los estudiantes temprano debido a una emergencia (clima, etc.), favor de indicar cómo niño(a) debe irse a su casa.

Please check ALL boxes that apply:

- ☐ Contact by phone any of the adults listed below in case of emergency / En caso de emergencia contacte a cualquier adulto nombrado en este documento abajo.
- ☐ My child who normally walks has my permission to walk home. / Mi niño(a) que usualmente camina puede caminar a casa.
- ☐ My child who normally is bused has my permission to be bused home. / Mi niño(a) que usualmente toma el autobús puede ir en autobús.
- ☐ My child may be dismissed to any one of the adults listed below. / Mi niño(a) puede ser recogido (a) por uno de los adultos nombrado abajo.
- ☐ My child may not be dismissed to anyone. / Mi niño (a) puede NO DEBE ser despachado con nadie.

All students dismissed to an adult must be met and signed out at the Principal's Office.

Todo estudiante despachado a un adulto se debe presentar al personal de la escuela ye tiene que firmar para recojer el estudiante en la oficina del director de la escuela.

	Name / Nombre	Telephone / Teléfono		
		Home / Casa	Work / Trabajo	Mobile / Móvil
Parent/Guardian #1 Padre/Tutor				
Parent/Guardian #2 Madre/Tutor				
Adult #1 / Adulto #1				
Adult #2 / Adulto #2				

Emergency Contacts / Información de emergencia

Two people we can notify in an emergency, if you are not available. Please list a neighbor or relative who lives nearby and who is generally at home
Dos personas que se pueda llamar por alguna emergencia y que estén en casa.

1	Name / Nombre		Telephone / Teléfono	Home.
	Address / *dirección*			Cell:
2	Name / Nombre		Telephone / Teléfono	Home
	Address / *dirección*			Cell:
	Doctor's Name / Nombre del Doctor		Telephone / Teléfono	Home:
	Address / *dirección*			

ATTENDANCE NOTIFICATION / NOTIFICACION DE ASISTENCIA

The School District routinely announces school related information by telephone, and also notifies parents of student absences. Please provide your preferred contact information to receive absence notices. / El Distrito Escolar anuncia habitualmente por teléfono información relacionada a las escuelas, incluyendo información sobre falta de asistencia a clases. Le pedimos proporcione el modo en el que desea ser informado sobre las faltas de asistencia.

School Related Calls:

Home / Casa	Work / Trabajo	Mobile / Móvil	Text 9 Digits / Texto	eMail

Regular Dismissal / Despido Normales

At Regular Dismissal my child will / Al Despido Regular mi niño(a)

☐ **Walk home alone / Caminar solo en casa**	☐ **Be picked-up / Va a ser recogido**
Persons Authorized to pick-up my child / Personas autorizadas para recogar a mi niño(a)	
1.	**2.**
3.	**4.**

Davis School Health Office
Phone: 914-576-4422
Fax: 914-576-4225

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name:	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Yes, indicate type ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Yes, indicate type ☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Yes, indicate type ☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Yes, indicate type ☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

Risk Factors for Diabetes or Pre-Diabetes:
Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother; and/or pre-diabetes.

BMI_____kg/m2 **Percentile (Weight Status Category):** ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre-K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ **System Review and Exam Entirely Normal**

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

Diagnoses/Problems (list)	ICD-10 Code

☐ Additional Information Attached

Name:	DOB:

SCREENINGS

Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		

Recommendations:

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School attached**

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	**Date:**
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

Please Return This Form To Your Child's School When Entirely Completed.

CITY SCHOOL DISTRICT OF NEW ROCHELLE
HEALTH SERVICES DEPARTMENT

STUDENT HEALTH HISTORY

Name:	**DOB:** **Age:** **Grade:**	**Gender:**
Parent/Guardian Name:	**Home Phone:** **Cell:** **Email:**	**Date:**

Your Child's Medical History	**YES**	**NO**	**If Yes, please explain and include date:**
Born premature or had complications after birth	☐	☐	
Has an ongoing medical or developmental condition	☐	☐	
Sees a medical specialist	☐	☐	
Has severe **allergies** or **anaphylaxis**	☐	☐	☐Food ☐Environmental ☐Insect ☐Medication ☐Other Specify:
Has been hospitalized	☐	☐	
Had an operation/required surgery	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a **concussion** or serious head injury	☐	☐	
Had a convulsion, has a **seizure disorder**, or **epilepsy**	☐	☐	
Has a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Has a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Wears a dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Allergies
☐ Asthma
☐ Autism
☐ **Diabetes**
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Condition
☐ High Blood Pressure
☐ Mental Health Condition (Depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis/Orthopedic Impairment
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition
☐ Speech Condition
☐ Urinary Condition
☐ EI/CPSE/CSE services_____

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐ No ☐ Yes: _____
Please list any additional concerns:

Parent/Guardian Signature: _____ **Date:** _____