THOMPSON PUBLIC SCHOOLS
HEALTH SERVICES

Name: _____
Date: _____

REGISTRATION GRADES 1-12
MEDICAL HISTORY

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ Grade Entering: _____ Male: _____ Female: ____

Telephone: _____ Last School Attended: _____

Mother/Guardian: _____ Telephone: _____

Mother/ Guardian Address: _____

Mother/ Guardian Place of Employment: _____ Telephone: _____

Father/Guardian: _____ Telephone: _____

Father/ Guardian Address: _____

Father/ Guardian Place of Employment: _____ Telephone: _____

Sibling Name: _____ Age: _____ Grade: _____
Sibling Name: _____ Age: _____ Grade: _____
Sibling Name: _____ Age: _____ Grade: _____
Sibling Name: _____ Age: _____ Grade: _____

Family Doctor:_____ Last visit to Doctor: _____
Reason: _____
Family Dentist: _____ Last visit to Dentist: _____
Reason: _____

Please indicate whether the child has had any of the following as well as dates:

	Yes	No	Date(s)		Yes	No	Date(s)
Rheumatic Fever				Allergies			
Scarlet Fever				Any contact with TB			
Measles				Operations			
Polio				History of Ear Infections			
Chicken Pox				Diabetes			
Whooping Cough				Seizures			
Mumps				Any unexplained illness			

(Over ->)

Does he/she have any physical or emotional problems? (speech, glasses, etc.) _____
_____

Does he/she take any medication daily? _____
Reason: _____

Does he/she have any reaction to bee stings? _____ Treatment: _____

Has he/she had a hearing test? _____ When/By whom? _____
Results: _____ Hearing loss? _____
Does he/she have tubes in their ears? _____ When inserted? _____

Has he/she had an eye exam? _____ When/By whom? _____
Results: _____

Was there anything unusual about the pregnancy with this child?
_____

Did this child require any special care after birth or in the first month after birth? _____
_____

Is there anything more about his child's health that you think is important for us to know?
_____
_____

CONSISTENT WITH CONNECTICUT GENERAL STATUTE 10-204a, YOUR CHILD MUST HAVE A VALID PHYSICAL AND IMMUNIZATIONS PRESENTED TO THE SCHOOL NURSE PRIOR TO SCHOOL ENTRY.

I UNDERSTAND IT IS THE PARENT/ GUARDIAN'S RESPONSIBILIY TO OBTAIN THE NECESSARY HEALTH RECORDS AND/OR TO ESTABLISH, WITH THE PHYSICIAN OF MY CHOICE, AN APPOINTMENT TO COMPLETE A PHYSICAL EXAMINATION, INCLUDING REQUIRED IMMUNIZATION, AND TO PROVIDE THE SCHOOL WITH THIS INFORMATION BEFORE MY CHILD WILL BE ALLOWED TO ATTEND SCHOOL.
CHILD'S NAME:
_____

PARENT SIGNATURE: _____

DATE: _____
HEALTH DEPARTMENT USE ONLY
Please check as each step is completed:

_____ Social/ Medical History is obtained
_____ Physical exam form given to parent
_____ Physical exam form completed
_____ Verification of Immunization
_____ Special Needs care plan completed
_____ Vision & Audio screening performed
_____ Emergency card completed