

MATANUSKA-SUSITNA BOROUGH SCHOOL DISTRICT  
**HEALTH REGISTRATION FORM**

Date of Enrollment \_\_\_\_\_ School \_\_\_\_\_ Mat-Su student number \_\_\_\_\_

Previously Attended a **Mat-Su** School? No \_\_\_ Yes \_\_\_ If yes- When/which school? \_\_\_\_\_  
 Last school attended (name and location if out of Mat-Su District) \_\_\_\_\_

Student's Name \_\_\_\_\_ M \_\_\_ F \_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_  
 Parent/Guardian (both) \_\_\_\_\_ Lives with (if other than parent) \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Physical address \_\_\_\_\_  
 Father: Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Mother: Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Additional contacts (neighbors, relatives, or friends, etc) who can pick up your child in case of illness or injury:

Name, relationship and phone \_\_\_\_\_ Name, relationship and phone \_\_\_\_\_ Name, relationship and phone \_\_\_\_\_

**STUDENT'S MEDICAL HISTORY:** (Please check at right of each health concern your child has now or has had previously)

	√	Year		√	Year		√	Year
Diabetes			Heart Problems			Bone/Joint Problems		
Epilepsy/Seizures			Leukemia/Cancer			Scoliosis/Back Curvature		
Asthma			Thyroid Problems			Behavioral/Emotional Problems		
Frequent Ear Infections			Ulcer/ Stomach Problems			Substance Abuse Treatment		
Ear Tubes			Kidney/Bladder Problems			Depression		
Hearing Problems			Frequent Bed/Clothing Wetting			Eating Disorder		
Glasses/Contacts			Chicken Pox			Hyperactivity/ADHD/ADD		
Vision Problems			Mono			<b>Other- (please specify)</b>		
Head Injury/Concussion			Pneumonia					
Skin Disease/Eczema			Coordination Problems					

For highlighted conditions, please fill out a separate care plan (see the nurse)

Allergies \_\_\_\_\_ reaction \_\_\_\_\_  
 Has your child ever had a **severe allergic reaction requiring emergency treatment or epinephrine?** Yes \_\_\_ No \_\_\_  
 My child has had surgery for: \_\_\_\_\_ My child has been hospitalized for: \_\_\_\_\_  
**Does your child take medication regularly?** Yes \_\_\_ No \_\_\_ What? \_\_\_\_\_  
 Will your child be taking medication at school? Yes \_\_\_ No \_\_\_ What? \_\_\_\_\_  
 Do you need to talk to the nurse about confidential information? Yes \_\_\_ No \_\_\_  
 Do you have concerns not covered above? If so, please explain: \_\_\_\_\_

Has your child had a **positive** reaction to a TB test? \_\_\_\_\_ If yes, was a Chest X-ray done and/or Treatment? \_\_\_\_\_  
 Date of X-ray and/or Treatment \_\_\_\_\_

I give permission for the School Nurse to give my child the following medications? Yes \_\_\_ No \_\_\_  
 Tylenol (acetaminophen) Advil (Motrin, Ibuprofen) Tums (calcium antacid) Cough Drops

Family Doctor: \_\_\_\_\_ Phone \_\_\_\_\_

In case of an area-wide disaster, my out-of-state emergency contact will be: \_\_\_\_\_  
 Name, relationship and phone \_\_\_\_\_

**TB Test:** I understand that my child will be given a TB skin test at intervals, as required by State Law 7AAC27.213, during the period they are enrolled in the Matanuska-Susitna Borough School District unless documentation is provided showing negative results in the previous 6 months or positive results from a PPD test.

**Release of Health Information:** I give the school nurse permission to share health related information regarding my child to other school district personnel on a need to know basis, eg. Teacher, Staff, Bus Driver, etc.

I understand my child will be transported by ambulance if I cannot be located and immediate emergency medical attention is necessary. I give permission for my family doctor or the physician on call to treat my child. I will assume financial responsibility.

DATE \_\_\_\_\_ SIGNATURE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_