

*A Place of Great Beginnings*



**Katie Winter**  
Principal

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Assistant Principal

## **MEDICAL REGISTRATION FORM**

*To be completed by parent/guardian*

Name of child: (Last) \_\_\_\_\_ First \_\_\_\_\_

☐ male ☐ female Date of birth: \_\_\_\_\_

Mother's name: \_\_\_\_\_

Father's name: \_\_\_\_\_

Native language spoken in the home: \_\_\_\_\_

Special problems/concerns: \_\_\_\_\_

### **Vision**

- a. Has your child ever seen an eye specialist for eye problems or defective vision? ☐ yes ☐ no  
b. If so, what was the result of the examination and recommendation, if any?

\_\_\_\_\_

### **Hearing**

- a. Has your child's hearing ever been tested? ☐ yes ☐ no  
b. If yes, what was the result of the examination and recommendation, if any?

\_\_\_\_\_

### **Other**

- a. Has your child had any other medical screenings or evaluations? ☐ yes ☐ no  
Date: \_\_\_\_\_  
b. If yes, what were the results and recommendations, if any?

\_\_\_\_\_

### **Dental**

- a. Has your child ever seen a dentist? ☐ yes ☐ no  
b. If so, for what reason?

\_\_\_\_\_

**Hospitalization**

- a. Has your child been hospitalized at all since birth? ☐yes ☐no Date: \_\_\_\_\_
- b. If so, what was the reason?

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c. Any other serious illnesses or injuries?

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**Allergies**

- a. Does your child have allergies? ☐yes ☐no
- b. Please list

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**Medications**

- a. Is your child presently taking any medications? ☐yes ☐no
- b. Please list:

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Please check if your child has a history of any of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Fracture                |
| <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Congenital heart failure | <input type="checkbox"/> Lyme disease            |
| <input type="checkbox"/> Coxsackie viruses        | <input type="checkbox"/> Pneumonia/bronchitis    |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Seizure                 |
| <input type="checkbox"/> Fifth's disease          | <input type="checkbox"/> Others                  |

Details:

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I understand that all reports and testing results provided to Primrose School will be treated confidentially.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature