PRIMROSE ELEMENTARY SCHOOL
Somers Central School District
PO Box 630, 110 Primrose Street
Lincolndale, New York 10540
914-248-8888 Fax: 914-248-5384

KATIE WINTER
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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 Date_____

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? _____

_____

c. Any other serious illness or injuries? _____

_____

Allergies

a. Does your child have any allergies? ◯ Yes ◯ No

b. Please list _____

_____

Medications

a. Is your child presently taking any medications? ◯ Yes ◯ No

b. Please list _____

_____

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

- ☐ Asthma
- ☐ Chicken Pox
- ☐ Congenital Heart Failure
- ☐ Coxsackie viruses
- ☐ Diabetes
- ☐ Fifth's Disease
- ☐ Fracture
- ☐ Frequent Ear Infections
- ☐ Lyme Disease
- ☐ Pneumonia/Bronchitis
- ☐ Seizure
- ☐ Others

Details: _____

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

_____ _____

Date Parent/Guardian Signature