OUR LADY OF VICTORY SCHOOL
New/Continuing Student Health Registration

Dear Parent/Guardian,

Completion of the following questionnaire will be helpful in assuring the best possible care of our students. If a health problem is present, you can readily understand our desire to have this information as soon as possible. This information will be available to appropriate school personnel working with the student. The information will be kept in the student's health record.

Date: ____/____/____ Entering Grade: _____

Name of Student: _____ Date of Birth: ____/____/____

Address: _____

Previous School Attended: _____

Health History-Please indicate if student has any of the following:

___Asthma: List Triggers:_____ Treatment/Medication: _____

___Bowel or Bladder Problems, please explain: _____

___Food Allergy:_____ Describe reaction: _____

Treatment/Medication: _____

___Medication Allergy:_____ Describe reaction: _____

___Seasonal/Environmental Allergy:_____Treatment/Medication: _____

___Other Allergy:_____ Treatment/Medication: _____

___Insect/Bee sting **(circle)**, please describe:_____Treatment/Medication: _____

___Attention Deficit Disorder:____Treatment/Medication: _____

___Bleeding Disorder:_____ Treatment/Medication: _____

___Cardiac (Heart) Disorder, Diagnosis:_____ Signs and symptoms _____

Does the student have any activity restrictions? _____

Treatment/Medication: _____

___Dental or Orthodontia devices: _____

___Diabetes: ___Insulin Pump ___Insulin Pen ___Syringe ___Glucagon ___Oral Medication

Insulin Type:_____ Insulin to Carbohydrate Ratio:_____

(Please obtain a separate Diabetes order form from the Health Room)

___Ear Infections: Frequency:_____ Date ear tubes inserted:_____ Are tubes still inserted? _____

___Hearing Disorder: Does student have assistive devices (hearing aids, cochlear implant, etc.)? _____

___Headaches (Please describe):_____ Treatment/Medication: _____

___Gastrointestinal Disorder:_____ Treatment/Medication: _____

___Immune System Disorder:_____Treatment/Medication: _____

___Muscular Disorder:_____Treatment/Medication: _____

___Neurological Disorder:_____Treatment/Medication:_____

___Psychological or Mental Health Disorder, please describe: _____

Treatment/Therapy/Medication:_____

___Seizures or Epilepsy: Type:_____ Describe symptoms or aura:_____

Medication:_____ Precautions needed at school:_____

(Please complete reverse side)

Student Name:_____

___Scoliosis: Surgery or Treatment dates:_____ Does student wear brace? _____

___Surgeries/Hospitalizations and dates: _____

___Speech Disorder:_____ Has student or does student receive therapy? _____

___Vision Disorder:_____ Glasses:_____ Contact Lenses:_____ Special concerns _____

___Other health problems or concerns: _____

Please use the space provided to discuss additional health concerns, medication , treatment or therapy:_____

_____

_____

_____

***If student requires medication to be administered at school, a separate medication order form is available in the Health Room and on the school's web site. No medication, prescription or over the counter, will be administered without this form, signed by the parent and a physician. If student requires an Epi-pen, a separate Epi-pen order form is available in the Health Room.**

Does your child have a health problem that would prevent full participation in school or physical education classes? _____

If so, provide the reason or diagnosis _____

You will need documentation from your child's physician if restrictions are required.

Does your child require preferential seating at school?_____ If so, why?_____

Do you anticipate any major problems with adjustment?____ If so, explain _____

Does your child have a doctor?_____Does your child have a dentist?_____

- **Please check off what your child may have during the school year:**

☐ **Non-medicated Cough Drops** ☐ **Baby Lotion** ☐ **Petroleum Jelly**

☐ **Regular Strength Tums** ☐ **Anti-itch Cream**

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

If you child has received any immunizations over the past year, please send an updated copy of the immunization record to the health room.

THANK YOU!

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