

Beatrice Public Schools
Registration Form — Student Health Information
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Student Name: _____ Student ID# _____

Teacher/Counselor _____
 Room _____
 Session AM PM

Health Concerns Parents/Guardians are responsible for providing full details on any medical condition to the school nurse

Check and explain where appropriate	Medication(s)	Medication Given At Home		Medication Given At School	
		YES	NO	YES	NO
<input type="checkbox"/> Allergies					
<input type="checkbox"/> Asthma					
<input type="checkbox"/> Attention Deficit Disorder					
<input type="checkbox"/> Bowel/Bladder					
<input type="checkbox"/> Diabetes					
<input type="checkbox"/> Emotional/Behavioral					
<input type="checkbox"/> Fractures					
<input type="checkbox"/> Head Injury					
<input type="checkbox"/> Hearing					
<input type="checkbox"/> Headaches					
<input type="checkbox"/> Heart					
<input type="checkbox"/> Hyperactivity					
<input type="checkbox"/> Seizures or Fainting					
<input type="checkbox"/> Skin Conditions					
<input type="checkbox"/> Speech					
<input type="checkbox"/> Surgeries / Hospitalizations					
<input type="checkbox"/> Tuberculosis					
<input type="checkbox"/> Varicella (Chickenpox)					
<input type="checkbox"/> Vision					
<input type="checkbox"/> Other					

Does your child have a health problem?

Student has NO health concerns

Please Check all that apply

- Glasses Contacts Hearing Aids
- Prosthesis or Physical Aids (please list)
- Other _____

Information obtained on the Health History is solely used by the school nurse to ensure that sound decisions are made to meet the health needs of your student. Health information will only be shared with school staffs on a "needs to know basis" and parents/guardians will be included in this process. Health information will not be shared with any other outside health providers without the expressed written permission of the parent/guardian. If you have any questions or concerns please contact your student's school nurse.

Parent Signature: _____ Date: _____