HEALTH REGISTRATION

Moravia Middle/High School

Grade Entering: _____

Gender: M F
(Circle One)

Child's Name: _____ *Last* _____ *First* _____ *Middle*

Street Address: _____ *Street* _____ *City* _____ *Zip Code*

Mailing Address: _____ *Include Post Office Box* _____ *City* _____ *Zip Code*

Home Phone #: _____

Date of Birth: _____

Mother's Name: _____ *Last* _____ *First* _____ *Maiden Name*

Father's Name: _____ *Last* _____ *First*

FAMILY PHYSICIAN:

Name: _____ Phone Number: _____

MEDICAL HISTORY: *Give the dates which your child has had the following diseases or conditions.*

_____	Chicken Pox	_____	Asthma	_____	Diabetes
_____	3-Day Measles	_____	Allergies	_____	Epilepsy
_____	Regular Measles	_____	Pneumonia	_____	Surgery
_____	Mumps	_____	Rheumatic Fever	_____	Serious Injury
_____	Heart Disease	_____	Scarlet Fever	_____	Other

Does your child have a vision problem? _____

Does your child have a hearing problem? _____

Does your child have a Speech or Language problem? _____

Does your child have <u>any other medical problems</u> which we should know about? _____

_____

_____

Has your child been examined by a specialist? Give name of specialist and year of examination:

	Name	Year(s)		Name	Year(s)
Pediatrician:	_____	_____	Psychologist:	_____	_____
Neurologist:	_____	_____	Psychiatrist:	_____	_____
Ophthalmologist:	_____	_____	Speech Clinic:	_____	_____
Optometrist:	_____	_____	Other Clinic:	_____	_____
Dentist:	_____	_____	Others:	_____	_____

Is your child on any medication(s): Y N
(Circle One)

If Yes, list medication(s): _____

REMINDER**: **Proof of immunizations must be furnished before entry of school.