Wilson School District Health Services
Kindergarten Registration Health Information

Student's name: First _____ Middle _____ Last _____
Birth date: _____ Sex: Male ___ Female ___
Home address: Street address _____ City _____ Zip _____
Home phone # _____ Cell phone# _____
E-mail address _____
Father's name: First _____ Middle _____ Last _____
Mother's name: First _____ Middle _____ Last _____
Student Lives with: _____ (name & relationship if other than biological parent)

STUDENT'S MEDICAL HISTORY: Please check yes or no for each

	Yes	No	Explain further where needed
ADD/ADHD			
Asthma			
Chickenpox			
Diabetes			
Food, drug or seasonal allergy			List allergies:
Bee Sting Allergy			
Glasses/Contacts			
Hearing Difficulties			
Seizure Disorders			
History of major illnesses or surgeries			List:
Condition limiting physical education			Describe:
Other chronic or recurrent condition			List:

If you have answered yes to any of the above health conditions, please write the plan of action you want the school nurse to take when the health condition arises. The school nurse may need to contact you to have a medical plan of action completed by your child's physician.

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*PLEASE NOTE: you must bring proof of your child's current immunizations to kindergarten registration even if the physical exam/boosters have not yet been completed.

Parent/Guardian signature _____ Date _____

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