

Kindergarten Registration Required Health Information

Please bring the following information to your child's kindergarten registration appointment:

Physical Examination:

- A copy of your child's most recent physical (MUST BE within the last 12 months)
- Pre-school vision screening from health care provider (MUST BE within the last 12 months)

Immunizations:

- 5 doses of DTaP/DTP (Diphtheria, Tetanus, Pertussis)/Td/Tdap
- 4 doses of Polio
- 3 doses of Hepatitis B
- 2 doses of MMR
- 2 doses of Varicella or physician documentation of history of chicken pox

Completed Health Forms:

- Emergency information form
- Health history form

Screenings:

- Lead Screening
- Tuberculosis (TB) test and results or completed Risk Assessment form

If your child is scheduled to have a physical/immunizations during the summer months, please request a copy from your doctor and send it to your child's school nurse before August 31, 2012.

Thank you for your cooperation.



Framingham Public Schools

School Health Services

29 Upper Joclyn Ave

Framingham, MA 01701

Ph: 508-626-9197

Fax: 508-620-4917

cover letter / Kindergarten reg./ 12-11

**FRAMINGHAM PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES
Student Emergency Information**

Student emergency contact information should be accurate and current. Please contact your school nurse with any changes.

Name of Student: _____ School: _____ Grade: _____

Home Address: _____ Phone: _____

Birth date: _____ Birthplace: _____

Father's Name: _____ Address: _____ Phone: _____

Cell : _____

Employer: _____ Phone: _____

Mother's Name: _____ Address: _____ Phone: _____

Cell: _____

Employer: _____ Phone: _____

In an emergency, if parents cannot be reached, the school is authorized to contact:

Name: _____ Address: _____ Phone : _____

Name: _____ Address: _____ Phone: _____

If serious illness or accident occurs at school, please call my child's physician:

Dr: _____ Phone: _____

In case of injury to teeth requiring emergency care, please call my child's dentist:

Dentist: _____ Phone: _____

I give parental permission to share my child's health information with school personnel who need to know? Yes No

Do you have health insurance? Yes No

Insurance Company: _____

Are you in need of information about Massachusetts's health insurance plans? Yes No

If so, in what language _____? Do you need assistance in filling out the insurance forms? Yes No

In the event of an emergency situation where parents cannot be contacted, I authorize the school to obtain medical/emergency treatment for my child.

Additional comments/information: _____

Signature of Parent/Guardian

Date

STUDENT HEALTH PROFILE - HISTORY

PLEASE PRINT

Last Name First Name

Date of Birth

Birthplace Primary Language

Developmental History

Any difficulties with the pregnancy, labor or delivery with your Child? Yes___ No___ Please describe _____

Was child born at full term? Yes ___ No _____

Was child born prematurely? Yes ___ No _____

How many week s early or late was child born? _____

Was the child in good condition at birth? Yes___ No___

What difficulties did the child experience as a newborn? _____

At what age did your child achieve the following milestones:

Roll over ___ Sit unassisted ___ Crawl _____

Walk independently ___ Talk _____

ALLERGIES:

Does your child have any allergies (bee, insects, food, medicine, environment)? Yes ___ No ___ Describe: _____

Are there any foods your child should not eat? Yes___ No___

What foods? _____

MEDICATIONS:

Does your child take any medications or treatments on a regular Basis? Yes___ No___

Describe reason for medicine or treatment: _____

<u>Medications</u>	<u>Dose</u>	<u>Prescribing MD</u>

<u>HAS YOUR CHILD HAD</u>	<u>Yes</u>	<u>No</u>	<u>Date</u>
Chicken Pox	___	___	___
German Measles	___	___	___
Measles	___	___	___
Mumps	___	___	___
Strep Infection	___	___	___
Pertussis	___	___	___
Polio	___	___	___
Diphtheria	___	___	___
Tuberculosis	___	___	___
Meningitis	___	___	___
Encephalitis	___	___	___
Pneumonia	___	___	___
Lyme Disease	___	___	___
Other: _____			

DOES YOUR CHILD HAVE A DR's DIAGNOSIS FOR:

	<u>Yes</u>	<u>No</u>	<u>Date</u>
Anxiety Disorder	___	___	___
Asthma	___	___	___
Attention Deficit Disorder	___	___	___
Sleep Disorder	___	___	___
Vision Difficulties	___	___	___
Cerebral Palsy	___	___	___
Cystic Fibrosis	___	___	___
Hearing Problem	___	___	___
Diabetes	___	___	___
Encopresis	___	___	___
Eating Disorder	___	___	___
Epilepsy/seizures	___	___	___
Heart Problems	___	___	___
Kidney Disease	___	___	___
Mental Health Issues	___	___	___
Migraine Headache	___	___	___
Muscular Dystrophy	___	___	___
Tourettes Syndrome	___	___	___
Other chronic Health condition	___	___	___

Explain: _____

Has your child had any SURGERY: Please Describe:

<u>Type</u>	<u>Hospital</u>	<u>Date</u>

HAS YOUR CHILD ANY TROUBLE WITH:

	Yes	No
Vision:	_____	_____
Speech:	_____	_____
Hearing:	_____	_____
Ears: frequent infections /earaches	_____	_____
Frequent sore throat	_____	_____
Enlarged tonsils or adenoids	_____	_____
Frequent nosebleeds	_____	_____
Sinus infections	_____	_____
Dental issues	_____	_____
Being overweight	_____	_____
Being underweight	_____	_____
Being thirsty all the time	_____	_____
Frequent headaches	_____	_____
Dizziness or fainting spells	_____	_____
Temper outbursts	_____	_____
Mood Swings	_____	_____
Skin conditions	_____	_____
Chest pain	_____	_____
Heart murmur	_____	_____
Persistent cough or wheezing	_____	_____
Fatigue	_____	_____
Stomachaches	_____	_____
Chronic constipation	_____	_____
Chronic diarrhea	_____	_____
Frequent urination	_____	_____
Burning with urination	_____	_____
Painful, swollen, stiff joints	_____	_____
Walking or mobility	_____	_____
Numbness, tingling, weakness	_____	_____
Sleep	_____	_____
Drug, alcohol, or tobacco use	_____	_____
Risky behaviors	_____	_____

If yes, please describe and give M.D. name, if under care _____

ACCIDENT/INJURY

<u>TYPE OF INJURY</u>	<u>HOSPITAL</u>	<u>DATE</u>
_____	_____	_____
_____	_____	_____

HOSPITALIZED FOR ANY OTHER CONDITIONS OR ILLNESS Yes___ No___

Problem	Hospital	Date
_____	_____	_____
_____	_____	_____

MENSTRUATION:

HAS YOUR DAUGHTER STARTED HER PERIODS

Yes___ No___
 Age at first period _____
 Describe any problems or concerns _____

Does she take medication to relieve discomfort or irregularity?
 Yes___ No___ What medication? _____

DOES YOUR CHILD USE ANY AIDS OR EQUIPMENT?

	YES	NO
Contact Lens	_____	_____
Eyeglasses	_____	_____
Hearing aid	_____	_____
Crutches	_____	_____
Braces for arm, leg or back	_____	_____
Wheelchair	_____	_____
Dental appliances or braces	_____	_____
Feeding tubes	_____	_____
Inhaler or nebulizer	_____	_____
Insulin pump	_____	_____
Oxygen	_____	_____
Catheter (urination)	_____	_____
Other, Please describe: _____		

CAN YOUR CHILD PARTICIPATE IN ALL SCHOOL ACTIVITIES? Yes___ No___

If no, please explain: _____

DOES ANYONE IN CHILD'S IMMEDIATE FAMILY HAVE A HISTORY OF:

	Yes	No	Relationship
Asthma	_____	_____	_____
Tuberculosis	_____	_____	_____
Seizures	_____	_____	_____
Diabetes	_____	_____	_____
Heart disease	_____	_____	_____
Obesity	_____	_____	_____

Parent/Guardian Signature _____ Date _____

**OVER-THE-COUNTER MEDICATIONS (OTC)
PARENT PERMISSION FORM**

The school physician for Framingham Public Schools, with the approval of the School Committee, and in compliance with Massachusetts Department of Public Health Regulations (105 CMR 210.00) has authorized the district's school nurses to administer the following over-the counter medications during the school day:

- IBUPROFEN (Advil, Motrin)—for headaches, body aches or menstrual cramps
- ACETAMINOPHEN (Tylenol)—for headaches, body aches or menstrual cramps
- BENADRYL—for general allergy symptoms
- TUMS/MAALOX—for upset stomach or indigestion
- Visine Allergy Relief—for eye allergy symptoms

To assure safe administration of OTC medications to students during the school day, the school nurse will:

- Assess the student's condition, current medication profile, history of allergies and evaluate the need for medication.
- Review the signed parent permission form, which is valid for one school year.
- Call the parent/guardian to confirm, when necessary, the time of the last dose given.
- Administer the correct dosage according to the physician's written protocols.
- Document the medication administration in the health office visit log.
- Contact parent/guardians who have requested notification following OTC medication administration during the school day.

School Health Services will provide the over-the-counter medications listed below.

I give my consent to the school nurse to administer the following medications as needed during the school day.

Please Circle All That Apply:

IBUPROFEN ACETAMINOPHEN BENADRYL TUMS/MAALOX VISINE ALLERGY RELIEF

School _____

Student's Name: _____ DOB _____

Parent's Signature: _____ Date: _____

Parent's Phone Numbers:

(wk) _____ (cell) _____ (home) _____

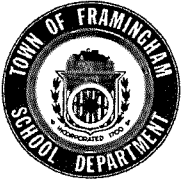
Please notify me when OTC medication is administered to my child during the school day.

Yes _____ No _____

Comments: _____



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Tuberculosis Risk Assessment

NAME _____ DOB _____ DATE _____

ADDRESS _____

Reason for TB screening/testing _____.

Was the child born outside the US? _____. Where _____.

Has the child been living outside the US? _____. How long? _____.

Has the child had a previous Tuberculin skin test? _____.

Where? _____ When? _____ Results? _____.

Has the child traveled outside the United States since being tested? _____.

If so has the child been tested since returning to the USA? _____

Results _____.

Has the child lived or spent time with anyone who possibly or definitely had Tuberculosis? _____

Does anyone living in the household have a positive tuberculin skin test? _____

Did anyone living in the household come to the US from another country? _____

Has the child lived or spent any time with adults who:

- Are homeless, living on the street or in a shelter? _____
- Have AIDS or are HIV infected? _____
- Used intravenous or street drugs? _____
- Lived in a correctional facility, nursing home or mental institution? _____

Office use only.

Previous TB test result _____ Date _____ Done at _____.

Patient is _____ is not _____ a candidate for a TB test.

RN