

Canton Public Schools
New Student Registration
Medical Questionnaire

Name of Child _____

Address _____ Telephone# _____

Date of Birth _____ Place of Birth _____

Father's Name _____ Mother's Name _____

Legal Guardian: Both Parents Father Mother Other (Name)

If divorced or separated, which residence is child living: _____

Father's Occupation _____ Mother's Occupation _____

Medical Data

Blue CT State Health Form with Immunizations Yes No (if entering gr. K, 7, or 11)

If No: Date of M.D. appointment: _____

Family Doctor/Primary Care Provider _____

Family Dentist _____

Name of Health Insurance Coverage _____

If your child is uninsured, would you like information regarding

State Husky Plan Yes No

School Accident Insurance Yes No

Has your child had any of the following? (Please describe)

Accidents (Date and description) _____

Allergies:

Food Yes No (if yes, describe reaction and treatment)

Insect Stings Yes No (if yes, describe reaction and treatment)

Medication Yes No (if yes, describe reaction and treatment)

Environmental Yes No (if yes, describe reaction and treatment)

Asthma	Yes	No	(if yes, list what triggers it)	_____		
Symptoms	_____					
Inhaler/medications?	Yes	No	(if yes, list name)	_____		
Seizures	Yes	No	(If yes, on any medication?)	_____		
Congenital Anomaly	Yes	No				
Diabetes	Yes	No				
Ear Infections	Yes	No	Ear Tubes	Yes	No	
Encephalitis	Yes	No	Rheumatic Fever	Yes	No	
Head Injury	Yes	No	Scarlet Fever	Yes	No	
Heart Disease	Yes	No	Scoliosis	Yes	No	
Hernia	Yes	No	Tonsillitis	Yes	No	
Kidney Disease	Yes	No	Strep Infection	Yes	No	
Lead Poisoning	Yes	No	Tuberculosis	Yes	No	
Meningitis	Yes	No	Whooping Cough	Yes	No	
Operations (include date)	Yes	No				

 Other _____

Please describe any physical disability or serious illness _____

Is your child receiving medication? Yes No (If yes, please list) _____

Additional information that may be pertinent to your child's well being? _____

Parent/Legal Guardian Signature _____ Date _____