Sanger Unified School District
New Student Health Registration Form

Date Completed: _____

Student name: _____ Birth Date: _____ Gender: _____

Parent/ Guardian completing form: _____#: _____

Medical Provider: _____#: _____Last Seen: _____

Dentist: _____ #: _____ Last Seen: _____

Other Health Providers: _____ _____

1. Has your child ever been diagnosed with a health condition? **Yes / No**
   a. **If Yes**, what is the condition? _____
   b. Treating Physician: _____ Age diagnosed? _____

2. Does your child take medications at home? **Yes / No**
   a. Medication #1/Dose: _____/ _____ #2: _____ /_____
   b. Prescribing Provider: _____ _____
   c. Will medications be needed at school? **Yes / No**
      If Yes, a 'Medication Authorization Form' from your child's provider is required
   d. Will a specialized diet be needed while at school? **Yes / No**
      If Yes, a 'Meal Authorization Form' from your child's provider is required

3. Has your child been hospitalized, had surgery or been in a serious accident? **Yes / No**
   a. **If Yes,** Please Describe: _____
   b. Dates: _____c. Facility: _____

4. Does your child wear glasses or contact lenses? **Yes / No**
   a. **If Yes,** are they worn: All the time **/** For reading only **(please circle one)**

5. Does your child have a hearing problem? **Yes / No**
   a. **If Yes**, please describe: _____

6. Were there any problems during pregnancy, labor or delivery? **Yes / No**
   a. **If Yes**, Please Describe: _____

7. Have you ever had concerns about your child's development? **Yes / No**
   a. **If Yes,** Please Describe: _____

8. Do you have any concerns about your child's behavior? **Yes / No**
   a. **If Yes,** Please Describe: _____

PLEASE CONTACT THE SCHOOL NURSE IF YOU HAVE FURTHER INFORMATION TO DISCUSS