

Please complete and sign before returning this to school. Thank you for your quick response.  
Please inform the office at 465-7207 if you have any changes of information during the school year.

## Mead School District #354

### REGISTRATION/HEALTH/EMERGENCY MEDICAL INFORMATION

Grade \_\_\_\_\_

Student Name \_\_\_\_\_ Legal Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(if Different)

Last First M.I.

#### HOME RESIDENCE

Household Description: Both Parents Mother Only Father Only Mother/Stepfather Father/Stepmother Guardian Agency Self Other (circle one)

Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Unlisted? Y N Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address if different from listed above: \_\_\_\_\_

#### SECONDARY RESIDENCE (If Applicable)

Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Unlisted? Y N Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address if different from listed above: \_\_\_\_\_

#### HEALTH HISTORY

**This information will be shared with those school district staff that need to know in order to provide a healthy, safe environment.**

HEART PROBLEM	Type:
	Special Needs:
DIABETES	Medication:
	Special Needs:
SEIZURE DISORDER Epilepsy, etc.	Type:
	Special Needs/Medication:
NEUROLOGICAL PROBLEM Hydrocephalus, Cerebral Palsy, etc.	Type:
	Special Needs/Medication:
A.D.D./A.D.H.D.	Special Needs/Medication:
SEVERE ALLERGIES TO: Foods, Insects, Medication, etc.	Type & Reaction:
	Medication Needed:
RESPIRATORY PROBLEM Asthma, Cystic Fibrosis, etc.	Severity:
	Special Needs/Medication:
ORTHOPEDIC PROBLEM Arthritis, Scoliosis, Braces, Wheelchair	Type:
	Surgeries/Limitations:
CANCER, LEUKEMIA, TUMORS	Type:
	Special Needs/Medication:
DIGESTIVE PROBLEMS Ulcer, Colitis, etc.	Type:
	Special Needs/Medication:
URINARY, KIDNEY DISORDER Nephritis, etc.	Type:
	Special Needs/Medication:
VISION PROBLEM OR COMPLETE LOSS	Describe:
	Special Needs/Correction:
HEARING PROBLEM OR COMPLETE LOSS	Describe:
	Special Needs:
SERIOUS ILLNESSES, INJURIES, OPERATIONS	Describe/Dates:
	Special Needs:
OTHER DIAGNOSED HEALTH PROBLEMS	Describe:
	Special Needs/Medications:

**NOTE: If medication is needed at school, please ask the school office for the appropriate forms.**

ADDITIONAL INFORMATION ON OTHER SIDE



STUDENT NAME: \_\_\_\_\_

If medication is needed at school, please ask the school office for the appropriate forms.

**ADDITIONAL INFORMATION**

Does your student qualify M/V? (circle one): YES NO

Is your student in Foster Care? (circle one): YES NO

Did your child attend preschool (Head Start, Early Start or private pre-kindergarten program)? (circle one): YES NO

\_\_\_\_\_ I **do not** authorize my child's image to be used in district publications (newsletters, web pages, yearbooks, Mead Matters, etc.)

\_\_\_\_\_ I **do not** authorize my child's "Directory Information" to be published in his/her school directory for distribution as specified by the Family Educational Rights and Privacy Act.

**EMERGENCY CONTACTS/AUTHORIZATIONS**

Does your child have a LIFE THREATENING ALLERGIC REACTION OR MEDICAL CONDITION? YES NO If so, describe

\_\_\_\_\_  
\_\_\_\_\_

Check here if any of the above health conditions concerning your child are life threatening. If so, State law requires that medication/ treatment orders and a nursing care plan be in place before the student attends school (RCS 28A.210).

**I authorize emergency treatment of the above named child by physician, dentist or the nearest hospital emergency room.**

Yes \_\_\_\_\_ No \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Verification of Information:**

The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the child's enrollment or assignment to a school in the Mead Public Schools. **I will notify the school each time there is a change in this information.**

→ \_\_\_\_\_  
Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ADDITIONAL INFORMATION ON OTHER SIDE** →