

Sacred Heart Catholic School

Yearly REGISTRATION FORM (update)

School Year: 2020-2021

STUDENT INFORMATION

Male	Female	Student's [Last Name]	Student's [First Name]	Middle [Initial]	Grade:	Date of Birth: [month/day/year]

Address [Primary]

City: _____ State: _____ Zip Code: _____

Address [Secondary]

[same as above]

Parent [Dad]

Parent [Mom]

City: _____ State: _____ Zip Code: _____

HEALTH INFORMATION

Student Name:

<input type="checkbox"/> No Health Problems	<input type="checkbox"/> Asthma/ Respiratory	<input type="checkbox"/> Frequent Headaches/Migraines	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Allergies [Food, latex etc.]	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> Other

Please explain any items checked above:

List any medication your child may need at school:

List any other health conditions or concerns you would like the nurse/teacher to know about:

Student Name:

<input type="checkbox"/> No Health Problems	<input type="checkbox"/> Asthma/ Respiratory	<input type="checkbox"/> Frequent Headaches/Migraines	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Allergies [Food, Latex etc.]	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> Other

Please explain any items checked above:

List any medication your child may need at school:

List any other health conditions or concerns you would like the nurse/teacher to know about:

Student Name:			
<input type="checkbox"/> No Health Problems	<input type="checkbox"/> Asthma/ Respiratory	<input type="checkbox"/> Frequent Headaches/Migraines	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Allergies [Food, latex etc.]	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> Other
Please explain any items checked above:			
List any medications your child may need at school:			
List any other health conditions or concerns you would like the nurse/teacher to know about:			
Student Name:			
<input type="checkbox"/> No Health Problems	<input type="checkbox"/> Asthma/ Respiratory	<input type="checkbox"/> Frequent Headaches/Migraines	<input type="checkbox"/> Eating Problems
<input type="checkbox"/> Allergies [Food, latex etc.]	<input type="checkbox"/> Seizures	<input type="checkbox"/> Anxiety/ Depression	<input type="checkbox"/> Other
Please explain any items checked above:			
List any medications your child may need at school:			
List any other health conditions or concerns you would like the nurse/teacher to know about:			
PARENT INFORMATION			
Mother's [Name]	Email Address:	Phone [Primary]	Occupation:
Father's [Name]	Email Address:	Phone [Primary]	Occupation:
<i>The above information is true to the best of my knowledge. I give permission to the school nurse to share education relevant health and emergency information [included medical diagnosis] with school staff on a need – to – know basis.</i>			
Patient/Guardian signature:		Date:	