MALONE CENTRAL SCHOOL DISTRICT
HEALTH SERVICES INTAKE FORM

TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL NURSE

1. Student Name: _____ Gender: M F
(Last) (First) (Middle) Circle One

Date of Birth: _____ Place of Birth: _____ Grade: _____
City State

2. Parent/Guardian Name:

_____
Last First M. (Relationship to Child)

_____
Last First M. (Relationship to Child)

Student lives with: [ ] Parent [ ] Both Parents [ ] Guardian [ ] Other _____
(Relationship to Child)

3. Home Address: _____
Street City/Town State ZIP

Phones: _____
(Indicate home or cell)

4. Parent/Guardian Employer:
Name: _____ Employer Phone: _____

Address: _____

5. Parent/Guardian Employer:
Name: _____ Employer Phone: _____

Address: _____

6. In an emergency, if neither parent/guardian can be reached at home or work, who may be called to come for your child?

_____
Name Relationship to Child Phone Number
(indicate home or cell)

_____
Address

7. Name of Family Physician/Pediatrician: _____Telephone #_____

Name of Family Dentist: _____Telephone #_____

8. Circle the conditions/diseases your child has had and give dates:

Allergies	_____	Epilepsy	_____	Rheumatic Fever	_____
Asthma	_____	Hearing	_____	Scarlet Fever	_____
Fractures	_____	Hernia	_____	Migraines	_____
Diabetes	_____	Kidney	_____	Vision	_____
Seizures	_____	Injuries	_____	Anemia	_____
Thyroid	_____	Nosebleeds	_____	Mononucleosis	_____

Other: _____

9. Does your child have/had a heart or lung condition? Yes/No_____

   If yes, please describe: _____

   _____

10. Has your child had any operations or surgeries? Yes/No_____

    If yes, please describe: _____

    _____

11. Has your child ever been stung by a bee? Yes/No _____

    If so, please describe reaction: _____

    _____

12. Has your child ever had or does your child currently have any activity restrictions? Yes/No_____

    If so, please describe: _____

    _____

13. Does your child take any medications? Yes/No_____

    If so, please list and state for what reason and when: _____

    _____

    _____

14. Does you child receive mental health counseling services? Yes/No_____

    Please give the name of agency and/or counselor: _____

    _____

15. Does you child have any food or medication allergies? Yes/No_____

    If so, list the allergies along with a description of your child's reaction to the allergies: _____

    _____

    _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____