

**PHYSICAL HISTORY ON REGISTRATION**

_____	_____	_____
Name of Child	Address	Birthdate and Place
_____	_____	_____
Parents' Names	Place of Employment	Tel. No. Home/Work

DOCTOR TO BE CALLED IN CASE OF EMERGENCY \_\_\_\_\_  
Name, Address, Telephone

Dentist's Name \_\_\_\_\_ Last Visit \_\_\_\_\_

**PHYSICAL HISTORY:  
WHAT DISEASES HAS CHILD HAD? (Give Dates)**

Chickenpox _____	Rheumatic Fever _____	Throat Infection _____
Scarlet Fever _____	Diabetes _____	Heart Disease _____
Pneumonia _____	Ear Infection _____	Epilepsy _____
Other _____		

Does your child have allergies, Asthma? YES NO EXPLAIN: \_\_\_\_\_  
(Circle one)

Does your child take medication? *If yes, give name of medication, dosage and for what condition* \_\_\_\_\_

Has your child ever had an accident, operation or x-rays? \_\_\_\_\_

Does your child have any handicap or limitation that the school should know of? \_\_\_\_\_

Is there anything about the eyes, ears, teeth or general health of your child that the school should know of? \_\_\_\_\_

**EMERGENCY CARE: IN CASE YOUR CHILD IS INJURED OR BECOMES ILL DURING SCHOOL HOURS WE WILL CONTACT YOU IMMEDIATELY BY PHONE. IF THAT IS NOT POSSIBLE PLEASE STATE BELOW WHAT ACTION YOU WISH THE SCHOOL TO TAKE AND THE NAME OF THE HOSPITAL FOR EMERGENCY SERVICE TO YOUR CHILD:**

**NAME & TELEPHONE OF PERSON TO CONTACT:** \_\_\_\_\_

**NAME OF HOSPITAL EMERGENCY ROOM:** \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

The Utica City School District is an equal-opportunity organization that does not discriminate on the basis of race, creed, Sex, age, handicapping condition, or national origin in admission or access to, or treatment or employment in, programs and activities.