

# EUREKA UNION SCHOOL DISTRICT

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## HEALTH REGISTRATION FORM

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

**Medications:** What medications does your child need at school (i.e. daily, emergency, as needed)?

**Allergies** (including food, seasonal/environmental, bee sting):

How does this allergy present?

Is emergency medication required for this allergy? If so, what?

**Developmental Information:** Has your child had any developmental delays or concerns? Please describe:

**Medical History:** Has your child had a problem in the following areas?

	Yes	No
Genetic Disorder		
Physical Disability		
Diabetes		
Intestinal/Stomach Problems		
Heart Problems		
Anemia/Blood Disorders		
Tumors		
Leukemia/Cancer		
Hepatitis/CMV		
Encephalitis/Meningitis		
Convulsions or Seizures		
ADHD		

	Yes	No
Family History of Learning Problems		
Fainting Spells/Dizziness		
Asthma		
Headaches/Migraines		
Eye/Vision Problems		
Ear/Hearing Problems		
Nosebleeds		
Frequent Urination or Bedwetting		
Skin Problems		
Eating Problems/Appetite		
Other		
Serious accidents, illnesses, surgeries, or hospitalizations		

If you checked "yes" to any of the above areas, please explain:

Please list current health conditions or diagnoses:

How would you describe your child's general health:      Good      Poor      **Comments:**

Is there any additional health-related information you would like the school to be aware of? Please explain:

Date: \_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_