## Health Registration Form

Student Name _____ DOB_____ SS#_____
Birthplace _____ Sex M F Grade_____
Address _____ Phone_____
Mother's Name _____ Father's Name _____
With whom does child reside?_____
Student's Physician _____Phone _____
Previous School Attended (if any)_____
Address_____ Phone_____
Indicate if your child has had any of the following, please include dates of illness:

| | | |
|---|---|---|
| Anemia_____ | Kidney Problem_____ | Heart Disease_____ |
| Tuberculosis_____ | Pneumonia_____ | Chicken Pox (Dr, Diagnosed)_____ |
| Contact with TB_____ | Diabetes_____ | Mumps (Dr. Diagnosed)_____ |
| Rheumatic Fever_____ | Epilepsy_____ | Measles (Dr. Diagnosed)_____ |
| Whooping Cough_____ | Heart Murmur_____ | German Measles (Dr. Diagnosed)___ |

Please answer the following questions, you may use the back of this page if more space is needed:
Is your child presently taking medication? _No _Yes
If yes, for what reason?_____
What is the medication?_____ Dosage?_____
How long has your child been taking this medication?_____
Have you ever suspected that your child may have a problem with vision? _No _Yes
Has your child ever been seen by an optometrist or an eye specialist? _No _Yes
If yes, what were the examination results and recommendations? _____
Name of optometrist or eye specialist _____
Have you ever suspected that your child may have a problem with hearing? _ No _Yes
Has your child ever had a hearing test? _No _Yes Date _____
If yes, what were the results?_____
Name of physician _____
Has your child had any other screenings for medical evaluation? _No _Yes
If yes, for what, and what were the results? _____
Name and phone number of physician _____
Has your child been hospitalized at all since birth? _No _Yes Date _____
If yes, for what reason? _____
During the past year, has your child had any illness, serious injury, or operation? _No _Yes
If yes, please describe _____
Is your child still receiving treatment? _No _Yes
If yes, please provide physician's name and phone number _____
Has your child ever been seen by a dentist? _No _Yes Date _____
If yes, for what reason?_____
Does your child have any allergies, which require attention at school? _No _Yes
If yes, please describe allergy, symptoms, and specific instructions for treating allergic reactions, especially to bee stings _____
Should your child be restricted from participating in school sports or gym? _No _Yes
If yes, please attach a written explanation and recommendations from your physician.

My child is physically fit and I know of no medical or health reasons whereby he/she should not take part in any/all athletic activities offered by the Waldorf School of Saratoga Springs.

_____ _____ _____
Parent/Guardian Signature Date


# 2017-2018
# WSSS Athletic/Club Program
# Intent Form

This form should be completed if you intend for your child to participate in any of the afterschool athletic/club programs.

Students Name_____ Grade_____Program_____

Students Name_____ Grade_____Program_____

Students Name _____ Grade_____Program_____

I can assist in the following ways:

____Driving ____Planning an Outdoor Club activity
____Coaching ____Other_____

____I am enclosing a check of $75 per child, made out to WSSS

Parent's Name_____

Parent's Email_____

Parent Emergency Contact Phone #:_____

Parent Signature_____

For Office Use:

CK # _____ CASH_____ Amount _____ NYP_____

Revised August 8, 2017