Chico Unified School District
HEALTH RECORD REGISTRATION

Student's Legal Last Name	Student's Legal First Name	Middle Name	Other Legal Name (if applicable)	
☐ Male ☐ Female	Birthdate: / /	Current School and Grade:		
Parent/Guardian Last Name	Parent/Guardian First Name	Home Phone	Cell Phone	Work Phone
Parent/Guardian Last Name	Parent/Guardian First Name	Home Phone	Cell Phone	Work Phone

Doctor/Primary Care Provider Name	Doctor/Primary Care Provider Phone and Fax Numbers
Eye Doctor Name	**Eye Doctor Phone and Fax Numbers**

Please check appropriate response for each condition listed below:

YES	NO		AGE	YES	NO	
		Previous Concussion				Wears Glasses
		Tendency to faint				Last Eye Examination date:
		Recurrent Headaches				Wears Contacts
		Difficulty with Speech				Hearing Loss

		Audiometrist:			
		Diabetes:	Insulin Dependent? ☐ Yes	☐ No	
		Asthma:	If yes, is inhaler needed?	☐ Yes ☐ No	
		Bee Sting reaction other than local swelling?	Epi pen Needed?	☐ Yes	☐ No
		Allergic reaction to medicine or food. If yes, please list:			
		Seasonal Allergies?			
		Heart Condition(specify):			
		Seizures: Type:			
		List any special health problem or physical disability that should be brought to the attention of the school nurse or teacher:			
		Complications during pregnancy: Explain:			
		Complications during delivery: Explain:			
		Medications, alcohol, tobacco, & drugs used during pregnancy			

Childhood (Fill in the blanks)		*Sleep & Rest Patterns*
Illnesses:		Average hours of sleep per night:
Accidents		Quality of sleep:

According to the Education Code, parents are required to inform the school their child is on routine medication.

Name of Medication(s):			
Medication(s) is taken at:	☐ Home	☐ School	☐ Home and School

My child has had SPECIAL SERVICES in a previous school ☐ Yes ☐ No

Please cKŜŏ] all that apply:

Speech	Resource Program	Adaptive Physical Education	
Special Day Class	504 Plan	IEP Services	Psychological Testing

Signature of Parent or Guardian Relationship Date

HS9b Rev. 4/4/22