COMPTON UNIFIED SCHOOL DISTRICT

Student Registration Form

Health Survey

Student's Name: _____
Student's Last Name Student's First Name Student's Middle Name

Gender: _____ (M / F / X) Date of Birth: _____ (Month day year)

☐ HMO ☐ HMS ☐ Other

Doctor's or Clinic's Name: _____

Doctor's/Clinic's telephone number and Extension: _____

Chronic Health Condition (Please describe.): _____

Medication (List all medications): _____

Health Conditions Has your child had any of the following conditions. Check ☑ all that apply.

☐	Known vision problems	☐	Muscle problems	☐	Mononucleosis
☐	Hearing problems	☐	Chicken Pox	☐	Mumps
☐	*Allergies (see below)	☐	Diabetes	☐	Rheumatic fever
☐	**Asthma (see below)	☐	Excessive colds	☐	Speech problem
☐	Birth defect	☐	Frequent ear infection	☐	Whooping cough
☐	Bone problems	☐	***Heart disease (see below)	☐	Seizure disorder
☐	Joint problems	☐	Hepatitis	☐	****Other (see below)

*Allergies (Please list all allergies.): _____

**Asthma (When was the last asthma attack?): _____

***Does the heart condition affect physical activity? ☐ Yes ☐ No

****If you checked ☑ "Other," please describe: _____