

# Canton Public Schools – Health History

Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Grade: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

## Birth History

Full Term (over 37 weeks): \_\_\_\_\_

Pre Term (# of weeks gestation): \_\_\_\_\_

Early Intervention? Yes ☐ No ☐

**Developmental Delays:** Did your child have any significant developmental delays (crawling, walking, talking)? Yes ☐ No ☐

When? \_\_\_\_\_

What happened? \_\_\_\_\_

**Allergies:** Does your child have any significant allergies (latex, medication, environmental)? Yes ☐ No ☐

Does your child have an Epi-Pen Yes ☐ No ☐

Has your child ever been stung by a bee or insect? Yes ☐ No ☐

When? \_\_\_\_\_

What happened? \_\_\_\_\_

Are there any foods your child should not eat or is allergic to:

What: \_\_\_\_\_

Reason: \_\_\_\_\_

Has your child ever had an allergic reaction to any medication?

Name of medication: \_\_\_\_\_

What happened? \_\_\_\_\_

**Medication:** Is your child taking any medication on a regular basis at home or in school? Yes ☐ No ☐

Name of medications: \_\_\_\_\_

For what reason? \_\_\_\_\_

Will medication be needed at school or on a field trip?

Yes ☐ No ☐

Which medications? \_\_\_\_\_

## Has your child had any:

Operations Yes ☐ No ☐ Serious accidents Yes ☐ No ☐

Fractured bones Yes ☐ No ☐ Concussion Yes ☐ No ☐

Hospitalizations Yes ☐ No ☐ Serious head injury Yes ☐ No ☐

Please give dates/details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Does your child have a history of:

ADD/ADHD Yes ☐ No ☐

Is he/she aware of the diagnosis Yes ☐ No ☐

Asthma/Wheezing Yes ☐ No ☐

Bleeding disorder Yes ☐ No ☐

Bone or joint disease Yes ☐ No ☐

Chicken Pox or Shingles Yes ☐ No ☐

Diabetes Yes ☐ No ☐

Depression Yes ☐ No ☐

Frequent nosebleeds Yes ☐ No ☐

Headaches: Yes ☐ No ☐

Chronic Yes ☐ No ☐

Migraine Yes ☐ No ☐

Hearing difficulties Yes ☐ No ☐

Heart conditions Yes ☐ No ☐

High blood pressure Yes ☐ No ☐

Skin problems Yes ☐ No ☐

Stomach/Bowel problems Yes ☐ No ☐

Scoliosis Yes ☐ No ☐

Seizure Disorder Yes ☐ No ☐

Last Seizure? \_\_\_\_\_

Yes ☐ No ☐

Seizures with fever \_\_\_\_\_

Visual problems Yes ☐ No ☐

Urinary problems Yes ☐ No ☐

Weight concerns (obesity, eating disorder) Yes ☐ No ☐

Other Yes ☐ No ☐

## Does your child use any of these aids?

Contact lenses Yes ☐ No ☐ Eye glasses Yes ☐ No ☐

Hearing aid Yes ☐ No ☐ Tubes in ears Yes ☐ No ☐

Crutches Yes ☐ No ☐ Wheelchair Yes ☐ No ☐

Brace for arm or leg Yes ☐ No ☐

Palate expander Yes ☐ No ☐

Orthodontic braces/retainer Yes ☐ No ☐

Other, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I give health personal permission to share relevant medical information with school staff, emergency medical personnel and my child's physician.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Please call the school nurse to discuss any of the above information or to ask questions. If needed, use the reverse side of the paper to make additional comments.

# CANTON PUBLIC SCHOOLS



960 Washington Street, Canton, MA 02021  
Telephone: 781-821-5060  
Fax: 781-575-6500  
www.cantonma.org



Derek F. Folan, M.Ed.  
*Superintendent of Schools*

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**To develop students who are competent and creative thinkers, curious and confident learners, and compassionate citizens.**

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## **RELEASE OF INFORMATION FORM**

Revised 7/1/2015

### **I hereby authorize and give permission to release my accumulated school records to:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Canton High School<br>900 Washington Street<br>Attn: Registrar<br>Canton, MA 02021<br>781-821-5050 Fax: 781-575-5052 | <input type="checkbox"/> William H. Galvin Middle School<br>55 Pecunit Street<br>Canton, MA 02021<br>781-821-5070 Fax: 781-575-6509     | <input type="checkbox"/> John F. Kennedy Elementary School<br>100 Dedham Street<br>Canton, MA 02021<br>781-821-5080 Fax: 781-575-6543  |
| <input type="checkbox"/> Lt. Peter M. Hansen Elementary School<br>25 Pecunit Street<br>Canton, MA 02021<br>781-821-5085 Fax: 781-575-6552     | <input type="checkbox"/> Dean S. Luce Elementary School<br>45 Independence Street<br>Canton, MA 02021<br>781-821-5075 Fax: 781-575-6528 | <input type="checkbox"/> Rodman Early Childhood Program<br>960 Washington Street<br>Canton, MA 02021<br>781-821-5060 Fax: 781-575-6500 |
| <input type="checkbox"/> Office of Student Services 960 Washington Street, Canton, MA 02021 781-821-5060 Fax: 781-821-5039                    |   |  |

### **To share, transfer, and receive information/records regarding my child:**

Student's Name: _____	Student's DOB: _____
Student's Address: _____	Year of Graduation: _____
Student's City/State/Zip: _____	SSN (if applicable): _____

### **To and from the following third party/school (students previous school of attendance):**

Name: _____	
Address: _____	Telephone #: _____
City/State/Zip: _____	Fax Number: _____

### **Information/Records to be released includes, but not limited to the following:**

Cumulative Records	Discipline Records
Transcript Information (includes identifying information, course titles, grades or their equivalent, and grade level completed)	Attendance Record
Teacher and Counselor Evaluations and Comments	Medical Records/Immunizations
Psychological Reports	Standardized Test Scores
Other _____	Special Education/IEP/504 Plan

\_\_\_\_\_  
\* Name of parent/guardian or student (please print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
\*\*Signature of parent/guardian or student

\_\_\_\_\_  
Date

\*This form may be signed by a student or former student of fourteen years of age or older, or a student in the ninth grade or above, or a parent/guardian.

\*\*Chapter 71, Section 37L (as amended by Section 37 of Chapter 71 of the Acts of 1993) of the Massachusetts General Laws. A student transferring into a local system must provide the new school with a complete school record of the entering student. Said record shall include, but not limited to any incidents involving suspension or violation of criminal acts, or any incident reports in which such student was charged with any suspended act.

\*\*\*Release is good for 1 year only. Release can only be used for intended purpose.

***The Canton Public Schools does not discriminate on the basis of race, color, religion, national origin, sex, gender identity, sexual orientation, age, disability or homelessness.  
Equal Opportunity Employer (EOE)***

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## Certification of Residency Form

It is the policy of the Canton Public Schools that proof of residence must be established by the student and his/her parent/guardian in accordance with the Canton Public Schools Residency and Registration Policy.

All persons registering a student with the Canton Public Schools shall be required to sign a certification of residency statement, which includes the penalties of perjury regarding the information provided. In addition, any person who falsely claims that a student lives with them, or the parents of that student, may be required to pay the full cost of the student's tuition to the Canton Public Schools, as well as any legal necessary legal fees.

### Certification of Residency

This is to certify that I have submitted the proof of residency documents required by the Canton Public School Committee to enroll \_\_\_\_\_ in the Canton Public  
(Name of student)

Public Schools. I understand that residency means that the student resides in the town of Canton and I certify that \_\_\_\_\_ returns to \_\_\_\_\_  
(Name of Student) (Address)

at the end of the day and spends the night at this address. I understand that if the Canton Public Schools investigates and finds these statements to be false, I may be held liable for repayment of any tuition or educational costs due to the Canton Public Schools for the education of the above referenced child(ren).

Signed under the pains and penalties of perjury this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(Month) (Year)

\_\_\_\_\_  
(Signature) Parent

\_\_\_\_\_  
(Signature) Guardian

\_\_\_\_\_  
\*\*\* (Signature) Canton resident with whom student resides (MUST SUBMIT  
HOMEOWNER /LANDLORD/BUILDING MANAGER AFFIDAVIT AND/OR  
CAREGIVER AFFIDAVIT)

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## Home Language Survey

Massachusetts Department of Elementary and Secondary Education regulations require that *all* schools determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students. If a language other than English is spoken in the home, the District is required to do further assessment of your child. Please help us meet this important requirement by answering the following questions. Thank you for your assistance.

<b>Student Information</b>		
First Name _____	Middle Name _____	Last Name _____
		Gender F <input type="checkbox"/> M <input type="checkbox"/>
Country of Birth _____	Date of Birth (mm/dd/yyyy) _____	Date first enrolled in ANY U.S. school (mm/dd/yyyy) _____
<b>School Information</b>		
Start Date in New School (mm/dd/yyyy) _____	Name of Former School and Town _____	Current Grade _____
<b>Questions for Parents/Guardians</b>		
What is the primary language used in the home, regardless of the language spoken by the student? _____	Which language(s) are spoken with your child? (include relatives -grandparents, uncles, aunts, etc. - and caregivers) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always	
What language did your child first understand and speak? _____	Which language do you use most with your child? _____	
How many years has the student been in U.S. Schools? (not including pre-kindergarten) _____	Which languages does your child use? (circle one) _____ seldom / sometimes / often / always _____ seldom / sometimes / often / always	
Will you require written information from school in your native language? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____	Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language? _____	
Parent/Guardian Signature: X _____	Today's Date: _____ / _____ /20____ (mm/dd/yyyy)	