# Niagara Falls City School District
# Gaskill Preparatory School

# 2017-18 21st Century Application

Child's Full Name (please print)_________Student I.D_____Male or Female (please circle)

Address_____ Zip Code (required)_____

School - _____ Grade entering _____

Mother/Guardian – (name)_____Home _____Work/Cell_____

Father/Guardian – (name) _____Home _____ Work/Cell _____

| **Emergency Contacts** | | | **Others Who May Pick Up My Child** | |
|---|---|---|---|---|
| **Name** | **Phone** | | **Name** | **Phone** |
| | | | | |

**Emergency Medical Information**

| In the event of a medical emergency, the Site Coordinator should call: | |
|---|---|
| Physician Name: | Phone: |
| In the event that I, or my child's physician cannot be reached in an emergency, I hereby give my permission to the physician's /hospital selected by the program to secure proper medical treatment for my child.<br><br>**Parent/Guardian Signature:** **Date**: | |

**Allergies and/or Special Needs**

*Please list any allergies to foods, bees, etc. and/or any special needs- i.e., asthma, seizures, etc.*

| Allergy or Special Need | Reaction | Action to be Taken |
|---|---|---|
| | | |

## Parent/Guardian Memo of Understanding:

- I give consent for my child to be photographed for education material, promotional articles or any other lawful purpose.
  **YES** **NO**
- I give consent for my child to attend all field trips using district transportation or 'walking field trips'.
  **YES** **NO**

**Parent/Guardian Signature: _____Date _____**

## My child needs help in area of:

******PLEASE RETURN TO:**
**Gaskill Preparatory School Main Office / HOME BASE TEACHER**

**Niagara Falls City School District**
**2017-2018 Extended School Day**
**Health History**

Child's Full Name _____

Date of Birth _____Male _____ Female _____

**ALL "YES" ANSWERS MUST BE EXPLAINED – Unexplained answers will delay clearance for your child.**

| **HAS/DOES the PARTICIPANT:** | **YES** | **NO** |
|---|---|---|
| 1. Had any recent injury, illness or infectious disease? | | |
| 2. Have a chronic or recurring illness/condition? | | |
| 3. Have a bleeding disorder? | | |
| 4. Ever had surgery? | | |
| 5. Have frequent headaches? | | |
| 6. Ever had a head injury? | | |
| 7. Ever had frequent ear infections? | | |
| 8. Ever had seizures? | | |
| 9. Ever had chest pain during or after exercise? | | |
| 10. Ever passed out during or after exercise? | | |
| 11. Ever had high blood pressure? | | |
| 12. Ever been diagnosed with a heart murmur? | | |
| 13. Ever had back problems? | | |
| 14. Ever had problems with joins (i.e., knees, ankles)? | | |
| 15. Have learning disabilities? | | |
| 16. Have behavior concerns such as ADD or ADHD? | | |
| 17. Have mobility concerns? | | |
| 18. Have an orthodontic appliance? | | |
| 19. Wear glasses, contacts, protective eye wear? | | |
| 20. Have any skin problems? (i.e., rash, acne) | | |
| 21. Have asthma? | | |
| 22. Have diabetes? | | |
| 23. Had mononucleosis in the 12 months? | | |
| 26. Ever had an eating disorder? | | |
| 27. Ever had emotional difficulties for which professional help was needed? | | |
| 28. Been taken out of GYM class this school year by his/her doctor? | | |
| If yes, was he/she returned to GYM by the doctor? | | |
| 29. Have medications he/she takes at school? | | |
| If yes, have your health care provider complete the attached medication form | | |

Please explain any "yes' answers, noting the corresponding number (use additional paper, if necessary)