REGISTRATION HEALTH RECORD

Name of Pupil_____ _____ _____ _____
Sex Date of Birth Place of Birth

Pupil's Address_____ Home Phone_____

Father's Name_____ Daytime Phone_____Cell/Pager_____

Mother's Name_____ Daytime Phone_____ Cell/Pager_____

Guardian's Name_____ Daytime Phone_____ Cell/Pager_____

Number of children living at home_____ Child lives with: Both parents___ Father___ Mother___ Guardian___

Please check appropriate response for each condition listed below:

Yes	No	Head	Age
		Concussion	
		Tendency to faint	
		Convulsions	
		Recurrent headaches	

Yes	No	Eye
		Glasses Full time [ ] Reading Only [ ]
		Contacts
Yes	**No**	**Ear, Nose, Throat, Mouth**
		Hearing loss
		Difficulty with speech

Yes	No	Special Needs
		Epilepsy: Type: Grand Mal [ ] Petit Mal [ ] Other [ ]
		Diabetes: Insulin Dependent? Yes [ ] No [ ]
		Asthma: Inhaler Needed? Yes [ ] No [ ]
		Bee Sting reactions other than mild local swelling EpiPen Needed? Yes [ ] No [ ]
		Allergic reaction to medicine or food. If so, please list:
		Heart Condition (specify):

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

Name of Medications(s): _____

Medication is taken at: Home [ ] School [ ] Home and School [ ] **If medication is brought to school and/or carried on your student's person, proper paper work is required and mandatory to have on file in health office. Please contact school health office for forms and information.**

List any special health problem or physical disability that should be brought to the attention of the school nurse or teacher:
_____

Family Doctor: _____

My child has had Special Services in a previous school. Yes___ No___ Please circle: Speech, Special Day Class, Resource Program, Psychological Testing, Adaptive Physical Education, Other: _____

PLEASE TURN OVER AND COMPLETE PAGE 2

_____ _____ _____
Signature of Parent or Guardian Relationship Date

If guardian, have guardianship papers been completed: Yes___ No___

THIS IS A PERMANENT RECORD

DEVELOPMENTAL HISTORY – Page 2

Name of Pupil: _____

Pregnancy with above-named child: (Mark appropriate word, or fill in blank)

1) Under doctor's care in _____month. Measles during pregnancy: Yes____ No____

2) Medications used during pregnancy: _____

3) Illness or accidents during pregnancy:_____

4) Health during pregnancy: Excellent___ Good___ Fair ___ Type of delivery: Vaginal____ Caesarean____

5) Delivery problems: Forceps____ Bleeding____ Breech____ Other:_____

Pupil:

1) Condition at birth: Birth weight_____ Cry: immediate___ delayed___ Color: pink ___ dusky___ blue____

Activity level:_____ Injury:_____ Seizures:_____

Birth defects: _____ Breathing problems:_____ Jaundice:_____

2) Childhood illnesses: _____ Accidents: _____

Describe: _____

3) Pupil's feeding and diet: Weight gain: slow____ average____ fast____

Appetite: good___ poor___ picky eater___ eats most foods___

Allergies: Infancy:_____ Present:_____

4) Pupil's sleep and rest patterns: Average hours per night_____ Sleeps: quietly___ restless___ dreams___

walks in sleep___ bed wetter___ needs naps___ rested after night's sleep___

5) Developmental landmarks - List age when he/she: sat alone_____ crawled_____ walked_____ first tooth_____ fed self_____

established bladder control_____ bowel control_____ Speech: first word_____ phrases_____ sentences_____