HEALTH RECORD REGISTRATION

Student's Legal Last Name	Student's Legal First Name	Middle Name	Other Legal Name (if applicable)
☐ Male ☐ Female	Birthdate: / /	Place of Birth	

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

Residence Address (street#, street name, apt.#)	City	State	Zip

Number of Children living at home	Child lives with: (Check appropriate box)				
	☐ Both Parents	☐ Mother	☐ Father	☐ Guardian	☐ Other:

Please check appropriate response for each condition listed below:

YES	NO	HEAD	AGE
		Concussion	
		Tendency to faint	
		Convulsion	
		Recurrent headaches	

YES	NO	EYE		
		Last Eye examination date:		
		Optometrist:		
		Glasses	☐ Fulltime	☐ Reading Only
		Contacts		

YES	NO	EAR, NOSE, THROAT AND MOUTH
		Hearing Loss
		Difficulty with speech

YES	NO	SPECIAL NEEDS			
		Epilepsy:	Type: ☐ Grand Mal	☐ Petit Mal	☐ Other:
		Diabetes:	Insulin Dependent?	☐ Yes	☐ No
		Asthma:	If yes, is inhaler needed?	☐ Yes	☐ No
		Bee Sting reaction other than mild local swelling	Epipen Needed?	☐ Yes	☐ No
		Allergic reaction to medicine or food. If yes, please list:			
		Heart Condition(specify):			

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

If medication is brought to school and/or carried on your student's property, proper paperwork 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/Primary Care Provider: _____

Please complete backside

THIS IS A PERMANENT RECORD

DEVELOPMENT HISTORY

Name of Student:

Pregnancy with above-named child: (Check appropriate boxes, or fill in blanks)						
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:	

Student:							
1. Condition at birth: (Check appropriate boxes, or fill in blanks)							
Birth Weight:	**Cry:**	☐ immediate	☐ delayed	**Color:**	☐ pink	☐ dusky	☐ blue
Activity Level:		**Injury:**			**Seizures:**		
Birth Defect(s):		**Breathing problem(s):**			**Jaundice:**		
2. Childhood:							
Illnesses:				**Accidents:**			
3. Feeding and Diet: (Check appropriate boxes, or fill in blanks)							
Weight Gain:	☐ slow	☐ average	☐ fast	**Appetite:**	☐ good	☐ poor	☐ picky eater ☐ eats moist foods
Allergies:	Infancy:			Present:			
4. Sleep and Rest patterns: (Check appropriate boxes, or fill in blanks)							
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:		Bowed control:					
Speech	First Word:	Phrases:	Sentences:				

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:				

Signature of Parent or Guardian Relationship Date

If guardian, have guardianship papers been completed: Yes____ No____

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