



HEALTH RECORD REGISTRATION

Student's Legal Last Name		Student's Legal First Name		Middle Name	Other Legal Name (if applicable)
<input type="checkbox"/> Male <input type="checkbox"/> 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)			
		<input type="checkbox"/> Both Parents	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Guardian <input type="checkbox"/> 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 <input type="checkbox"/> Fulltime <input type="checkbox"/> Reading Only
		Contacts

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

YES	NO	SPECIAL NEEDS
		Epilepsy: Type: <input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other:
		Diabetes: Insulin Dependent? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Asthma: If yes, is inhaler needed? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Bee Sting reaction other than mild local swelling Epipen Needed? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Home	<input type="checkbox"/> School	<input type="checkbox"/> 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:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Medications used during pregnancy:				
3. Illness or accidents during pregnancy:				
4. Health during pregnancy:	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	Type of delivery: <input type="checkbox"/> Vaginal <input type="checkbox"/> Caesarean
5. Delivery Problems:	<input type="checkbox"/> Forceps	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Breech	<input type="checkbox"/> Other:

Student:						
1. Condition at birth: (Check appropriate boxes, or fill in blanks)						
Birth Weight:	Cry:	<input type="checkbox"/> immediate	<input type="checkbox"/> delayed	Color: <input type="checkbox"/> pink <input type="checkbox"/> dusky <input type="checkbox"/> 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:	<input type="checkbox"/> slow	<input type="checkbox"/> average	<input type="checkbox"/> fast	Appetite: <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> picky eater <input type="checkbox"/> eats moist foods		
Allergies:	Infancy:		Present:			
4. Sleep and Rest patterns: (Check appropriate boxes, or fill in blanks)						
Average hours per night:		Sleeps:	<input type="checkbox"/> quietly	<input type="checkbox"/> restless	<input type="checkbox"/> dreams	<input type="checkbox"/> walks in sleep
			<input type="checkbox"/> bed wetter	<input type="checkbox"/> needs naps	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please circle:	Speech	Special Day Class	Resource Program	Psychological Testing	Adaptive Physical Education
	Other:				

Signature of Parent or Guardian	Relationship	Date
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If guardian, have guardianship papers been completed: Yes ___ No ___

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