LINDENWOLD PUBLIC SCHOOLS
LINDENWOLD, NEW JERSEY

PRE-SCHOOL / KINDERGARTEN / FIRST THROUGH FOURTH GRADES REGISTRATION
CONFIDENTIAL HEALTH HISTORY

Child's Name_____ Sex ____M ____F Date of Birth_____
Parents'/Guardians' Names _____ Address _____
Phone Number _____
Health Care Provider (physician/nurse practitioner) _____ Phone Number _____

I. Pregnancy & Birth (Check One)

1. Did mother have any illness during pregnancy with this child? ____Yes ____No
2. Did you deliver on your due date?
   If not, explain_____ ____Yes ____No
3. Did mother have any difficulty during delivery?
   If yes, explain_____ ____Yes ____No
4. Did your child have any difficulty during or after delivery?
   If yes, explain_____ ____Yes ____No
5. Did your baby have any trouble starting to breathe? ____Yes ____No
6. Did your child have any trouble in the hospital?
   If yes, explain_____ ____Yes ____No
7. What did the child weigh at birth? ____Lbs. ____Ozs.

II. Family/Social

1. Are both parents in good health? ____Yes ____No
2. Are there any family members with serious health problems that we should be aware of? If so, please explain _____ ____Yes ____No
   _____

III. Development Milestones (Place Age or Check Mark)

1. Sitting Alone	____months	6. Dressed self	____years
2. Crawled	____months	7. Fed self	____years
3. Walked alone	____months	8. Ties shoes	____years
4. Spoke first words	____months	9. Toilet trained	____years
5. Spoke sentences	____year		

10. Does your child play with children other than brothers/sisters? ____Yes ____No
11. Is your child independent_____? Shy_____?
12. Which hand does your child use for most tasks? Right ____Left ____Both_____
13. Ride a tricycle? ____years
14. Are you concerned about any of the following (Check)

Bad tempered	____	Will not mind	____	Holds his/her breath	____
Jealous	____	Sleep problems	____	Thumb sucking	____
Nail biting	____	Stuttering	____	Understanding speech	____

IV. Medication

Is the student on any type of medication at this time? ____Yes ____No
If yes, please list medicine, dosage and reason for administration of same:_____ ____Yes ____No

-OVER-

Infections, Illnesses, and Other Problems

Has your child:

1. Had more than six (6) colds or throat infections each year? ____Yes ____No
2. Had more than three (3) ear infections? ____Yes ____No
3. Had trouble hearing? ____Yes ____No
4. Had his/her hearing tested? ____Yes ____No
5. Had any trouble seeing? ____Yes ____No
6. Had his/her eyes tested? ____Yes ____No
7. Had any trouble with his/her teeth? ____Yes ____No
8. Seen a dentist recently? ____Yes ____No
9. Had any trouble passing his/her urine? ____Yes ____No
10. Check any of the following that your child has had?

Strep Infection	____	Rheumatic Fever	____	Speech Impediment	____
10-Day Measles	____	Headaches	____	Bedwetting	____
3-Day Measles	____	Blackouts	____	Poor Concentration	____
Mumps	____	Epilepsy	____	Abnormal Movements	____
Scarlatina	____	Convulsions	____	Over-activity	____
Pneumonia	____	Vision Problems	____	Temper Tantrums	____
Whooping Cough	____	Un-coordination	____	Aggressiveness	____
Chicken Pox	____	Hearing Loss	____	Brain Trauma	____
Concussion	____				

11. Had other diseases:
    If so, name them_____
    Had to stay in the hospital overnight? ____Yes ____No
    Age_____ Hospital_____
    Reason _____
12. Had your child had any serious accidents? Operations ____Yes ____No
    If yes, explain_____

Allergies (Check if applicable)

Wheezing	____	Sinus trouble	____	Hives	____
Eczema	____	Reaction to medication	____	Hay Fever	____
Asthma	____	Reaction to insect bites	____	Reaction to Penicillin	____

Nutrition

Food allergies_____
Food likes _____Food dislikes_____
Appetite – good _____poor _____snack eater_____
Unusual weight gain or weight loss_____

Summary

Is there anything in regard to your child's habits, health or behavior that you would like to comment upon?

_____

_____

PARENT'S/GUARDIAN'S SIGNATURE_____DATE_____

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