**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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