Elmsford Schools
Health History Registration Form

Kindly complete this form and bring it to the school at the time of registration for reference with the school nurse.

Child's Name _____ Sex _____

Date of Birth _____ Place of Birth _____
Hospital or home; city and state

Birth History:

	Yes	no
Was mother ill during pregnancy?		
Was birth normal?		
	Lbs	oz
Child's weight at birth		

Health History and Development:

Does your child have a good appetite and eat regular meals? Yes____ No____

How many hours sleep does your child average per night? _____

Does your child have difficulty getting to sleep? Yes____ No____

Please describe any problems such as bedwetting, sleepwalking, nightmares, etc.:

_____

Does your child share a bedroom? Yes ____ No____ If yes, with whom? _____

At what age did your child start to walk? _____

At what age did your child start to talk? _____

Describe any speech difficulty such as a lisp, stuttering, or difficulty with certain sounds:

_____

Is your child accustomed to a nap during the day? Yes____ No____

At what age was your child toilet trained? _____ Was it a difficult experience? Yes ____ No____

How much assistance does your child need with dressing? _____

Has your child had the expericnce of playing with other children in his age group? Yes____ No____

Please indicate how much: Little ____ Average ____ A great deal ____

Has your child ever been away from home? Yes____ No____

Does your child live with Parents or others? _____

Who is the main daytime caregiver, if other than the parents? _____

What is the relationship of this caregiver to your child? _____

How many people are living together in the home? _____

Number of siblings or other children in the home: _____ What are their ages? _____

List any special habits such as thumb sucking, fears, temper tantrums: _____

Any emotional problems? Yes____ No____ If yes, please explain _____

Any hearing loss? Yes____ No____ If yes, which ear?_____ Currently under treatment? _____

Any vision problem? Yes____ No____ If yes, please explain: _____

Are glasses required? Yes____ No____ Date of last professional examination: _____

Has your child ever been to a dentist? Yes____ No____ If yes, was care completed? Yes____ No____

Does your child have any allergies (including bee & insect bites?) Yes____ No____

If yes, what are they? _____

Are there any foods that your child should *NOT* eat? Yes____ No____

If yes, please list them: _____

Does your child take any medications or treatments on a regular **or** part-time basis? Yes____ No____

If yes, list medications or describe treatment: _____

Has your child had any of the following:

Operations	Yes____ No____	Describe_____	
Serious accidents	Yes____ No____	Describe_____	
Fractured (broken) bones	Yes____ No____	Describe_____	
Head injuries	Yes____ No____	Describe_____	

Has your child ever been hospitalized for any condition? Yes____ No____

Date: _____ Hospital _____ Disease or Condition _____

Has your child had:

Chicken pox	Yes____	No____	Rhumatic Fever	Yes____	No____
Measles	Yes____	No____	Tuberculosis	Yes____	No____
German Measles	Yes____	No____	Pneumonia	Yes____	No____
Mumps	Yes____	No____	Other (specify)	_____	_____

Does your child have:

Asthma	Yes____	No____	Cerebral Palsey	Yes____	No____
Diabetes	Yes____	No____	Frequent headaches	Yes____	No____
Epilepsy	Yes____	No____	Frequent sore throats	Yes____	No____

Has anyone in your family had:

Asthma	Yes____	No____	Tuberculosis	Yes____	No____
Diabetes	Yes____	No____	Convulsions	Yes____	No____
Heart attack (under 45)	Yes____	No____	Nervous trouble	Yes____	No____
Are any conditions under medical care:	Yes____	No____			

Immunizations: *We must have exact dates for both SERIES and BOOSTERS. The M.D.'s paperwork may be attached.*

Smallpox	series ____	booster ____	Triple Vaccine (DPT)	series ____	booster ____
Diphtheria*	series ____	booster ____	Whooping Cough	series ____	booster ____
Tetanus	series ____	booster ____	Sickle Cell	series ____	booster ____
Mumps*	series ____	booster ____	Measles Vaccine*	series ____	booster ____
Polio - Salk (injection)	Yes___	No ____	Polio - Sabin (oral)	Yes ____	No ____
Tuberculin Test	series ____	booster ____	Rubella*	series ____	booster ____

Can your child participate in all school activities? Yes _____ No _____

If no, please explain:

_____

Please describe any health problems that have not already been mentioned:

_____

_____

Are you in need of help about your child's health as it applies to school? If yes, please explain: _____

_____

Parent's Signature_____ Parent's Signature _____

Address _____ Phone _____

Person to call in an emergency: _____ Phone _____

Family Physician: _____ Phone _____