Haddon Heights School District

SERVING THE COMMUNITIES OF HADDON HEIGHTS, BARRINGTON AND LAWNSIDE

# HADDON HEIGHTS ELEMENTARY SCHOOLS
# REGISTRATION FORM

**Name**_____
**First** **Middle** **Last**

**Name used in school**_____

**Address**_____ **Home Phone**_____

**Date of Birth**_____ **Sex: Male**_____ **Female**_____**Grade**_____

**Birth City** _____ **Birth State** _____ **Birth Country** _____

**Race and Ethnicity: (Please check all that apply)**

**Hispanic or Latino**_____ **Asian**_____ **African American**_____ **White**_____
**American Indian or Alaska Native**_____ **Native Hawaiian or other Pacific Islander**_____
**Multiracial**_____ **Other** _____

**Family Doctor**_____**Phone**_____

**Child's Doctor (if different from above)**_____**Phone**_____

**Parent**_____

**E-mail**_____

**Cell phone**_____

**Employer**_____**Occupation**_____

**Employer's Telephone No.** _____

**Parent**_____

**E-mail**_____

**Cell phone**_____

**Employer**_____**Occupation**_____

**Employer's Telephone No.** _____

Marital Status of Parents: Married_____ Separated_____ Divorced_____ Single_____
Civil Union____ Mother Deceased_____ Father Deceased_____

**Child lives with: Both parents_____ Mother_____ Father_____ Other-Specific _____**

**Other children in household?**

| Name | Birthday | Grade | School |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Other residents living in the home and relationship_____**

**Legal Guardian (if other than parent)**
**_____**

**Are there any custody issues or restraining / protective orders? Yes _____ No_____**
**Type? Please attach a copy**

**_____**

**Alternate names and telephone numbers to call if parent is not at home:**

**1._____**

**2._____**

**Did your child attend nursery school / pre-school? (Kindergarten only)**
**If so, where_____**

**May we contact your child's previous school? Yes_____ No_____**

**Is your child: right handed_____ left handed_____ not sure_____**

**Has your child ever been evaluated by a Child Study Team?**
**Yes_____No_____**

**Does you child have an IEP? Yes_____ No_____**

**Does your child have a 504 plan Yes_____ No_____**

**Has your children ever been retained Yes____ No_____ What grade_____**

**Would you like to speak with school personnel regarding your child's readiness?**
**_____**

For office Use only:

| | |
|---|---|
| Date Form Submitted | |
| Birth Cert Received | |
| Proof of Residence | |
| Immunization Up To Date | |
| Physical | |

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# Medical History Form

**Parent/guardian to complete this form and return it to the nurse's office**

Student's Name_____ D.O.B._____
Doctor's Name_____
Date of last physical exam_____

Has your child had any of the following :

| Illness | No | Yes | Date of Illness |
|---|---|---|---|
| Chickenpox | | | |
| Measles | | | |
| Mumps | | | |
| German Measles | | | |
| Lyme Disease | | | |
| Frequent Strep. Infection | | | |
| Scarlet Fever | | | |
| Rheumatic Fever | | | |
| Mononucleosis | | | |
| Hepatitis (type) | | | |

Does your child have any of the following :

| | No | Yes | Explain |
|---|---|---|---|
| Nosebleeds | | | |
| Seizures | | | |
| Diabetes | | | |
| Asthma | | | mild or severe |
| Allergy to foods | | | food & reaction |
| Allergy to medication | | | med. & reaction |
| Bee sting allergy | | | reaction |
| Seasonal allergies | | | season & symptoms |
| Vision problem | | | |
| Hearing problem | | | |
| Tubes in ears | | | |
| Muscle problems | | | |
| Broken bone history | | | |
| Past surgery | | | |
| Other medical problems | | | |

Has your child ever been hospitalized? **No_____ Yes_____**
If yes, please indicate date and reason_____

Is your child currently on any daily medication? **No_____ Yes_____**
If yes, please give name of medication, amount and reason. If any medication needs to be given during school hours a consent form will need to be completed by the parent and doctor ordering the medication (including over the counter medications)._____

I give permission for health concerns information to be shared with appropriate staff having contact with my child

**No_____ Yes_____**

## Parent/guardian signature

_____

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**Child Health Assessment**
**To be filled out by MD**

**Name**:_____ DOB: _____
Address_____
Phone: _____
*Health history and medical information pertinent to routine child care emergencies:*
_____
**Allergies / Reactions:**
_____
**PHYSICAL EXAM** Date: _____
**Wt Readings from Last Encounter:** **Ht Readings from Last Encounters:** **BP Readings from Last Encounter:**
_____ _____ _____

HEENT: _____
Teeth: _____
CV / Resp:_____
GU/Breast: _____
Abdomen:_____
Ext/Back: _____
Skin/Lymph: _____
Neurological: _____
Developmental: _____

| **Immunization History – Document or Attachment** | |
|---|---|
| DTaP | |
| IPV | |
| Hib | |
| Hepatitis B | |
| Hepatitis A | |
| Pneumococcal Conjugate | |
| MMR | |
| Varicella | |
| Influenza | |
| Menectra | |
| Tdap | |

*Screening Test Summary if Done*
**Lead:** _____
Anemia (Hgb/Hct): _____
Urinalysis (UA): _____
Hearing: _____
Vision: _____
Date of Last Dentist Exam:_____
Medications: Name, Route, Frequency—If medication to be given in school need separate med form

_____

MD Signature_____ Date_____

Office (Name / Address Or Stamp ) _____

_____