DELAWARE VALLEY SCHOOL DISTRICT

MILFORD, PENNSYLVANIA

HEALTH REGISTRATION FORM

Date of Entry _____ **School** _____

Child's Name _____ **DOB** _____ **Gender: Male Female**

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When your child enters school, we establish a cumulative record file on him/her to enable us to have a greater understanding of your child's needs. All information, of course, will be kept strictly confidential, so please answer every question

Health History:

Asthma or Bronchitis: _____

Allergies: Foods, Drugs, Hay Fever, Grasses, Animals – PLEASE BE SPECIFIC: _____

Any Hospitalization, stitches or fractures? _____

Family History of Color Blindness: _____If yes, whom? _____

Eye Glasses: Yes_____ No _____ Contacts: Yes_____ No_____ It is advised that every child wearing eye glasses should receive periodic eye examinations. The school would appreciate a report of exam and name of examiner together with his/her recommendations for the school.

Does your child have any other medical conditions? Yes_____ No_____

List: _____

Does your child take any medication? Yes_____ No_____ If so please list_____

History of Infancy and Early Childhood: (Elementary Level)

Has your child shown any of the following? (Answer Yes or No)

1. Extreme Activity _____ Comment: _____
2. Extremely Tired/Sleepy _____ Comment: _____
3. Frequent Headaches _____ Comment: _____
4. Temper Tantrums _____ Comment: _____
5. High Fevers _____ Comment: _____
6. Fainting _____ Comment: _____
7. Convulsions/Seizures _____ Comment: _____
8. Feeding Problems _____ Comment: _____
9. Bowel/Bladder Problems _____ Comment: _____
10. Allergies _____ Comment: _____
11. Frequent Stumbling/Falling _____ Comment: _____
12. Poor Coordination _____ Comment: _____
13. Nail Biting _____ Comment: _____
14. Eye Blinking _____ Comment: _____
15. Stuttering _____ Comment: _____
16. Bed Wetting _____ Comment: _____
17. Thumb Sucking _____ Comment: _____
18. Other Habits/Problems _____ Comment: _____
19. Any Injury to Eyes/Head/Neck _____ Comment: _____
20. Any Hospitalizations _____ Comment: _____
21. Any family history of birth defects, disorders, heart disease, diabetes, TB? _____ Comment: _____
22. Has your child been to any clinic or other agencies? _____ Comment: _____
23. Do you always understand your child's speech? _____ Describe _____
24. Does your child have a history of hearing loss? _____ Describe _____
25. Has your child every received any speech/language services? _____ If so, where? _____