THOMPSON PUBLIC SCHOOLS
HEALTH SERVICES

Name: _____
Date: _____

PRE-SCHOOL & KINDERGARTEN REGISTRATION

Name: Last: _____ First: _____ Middle: _____

DOB: _____ Grade: _____ Male: _____ Female: _____

Address: _____

Telephone: _____

Mother's Name: _____ Father's Name: _____

Siblings and their ages: _____

_____ This child is _____ in the family.
(number)

1. With whom does this child live? _____
2. When did your child last have a physical exam or visit to M.D.? _____
(Date)
3. When did your child have a dental exam? _____
(Date)
4. Has your child had any accidents operations since birth? (circle one) YES NO
5. Has your child had any of the following? Please √ yes or no. Give date and comment if needed.

	YES	NO		YES	NO
Frequent colds	_____	_____	Mumps	_____	_____
Frequent stomachaches	_____	_____	Measles	_____	_____
Frequent headaches	_____	_____	Polio	_____	_____
Strep throat	_____	_____	Chicken Pox	_____	_____
Rheumatic fever	_____	_____	Epilepsy	_____	_____
Scarlet fever	_____	_____	Tuberculosis	_____	_____
Bronchitis	_____	_____	Cancer	_____	_____
Pneumonia	_____	_____	Heart disease	_____	_____
Seizures	_____	_____	Attention deficit		
Anemia	_____	_____	disorder	_____	_____
Diabetes	_____	_____	Other illness: _____		
Whooping cough	_____	_____	_____		

Comments: _____
_____

6. Does your child have asthma? (circle one) YES NO
   If yes, briefly describe frequency, symptoms, and medication prescribed to be given at home or in school: _____
   _____

7. Does your child have an allergy to bee stings? (circle one) YES NO Never Stung

   If Never Stung, does any family member have severe reactions?
   Describe: _____

   If Yes, please √ type of reaction:
   _____ Local swelling _____ Generalized swelling _____ Hives
   Please describe treatment and medication to be given at school in case of bee sting reactions: _____

8. Does your child have any environmental, food, or medication allergies?(circle one) YES NO
   If yes, please specify: _____
   Describe reaction: _____
   Treatment or medication to be administered at school in case of reaction: _____
   _____

9. Does your child take any medication daily? (circle one) YES NO
   If yes, specify name and reason: _____

10. Does your child have any physical limitations or restrictions for activity?(circle one) YES NO
    If yes, Explain: _____

11. Does your child have frequent ear infections? (circle one) YES NO
    Has you child had a hearing test? (circle one) YES NO
    If yes, Date: _____ Name of M.D.: _____
    Results found: _____
    Does your child have tubes in his/her ears? (circle one) YES NO
    If yes, dates of insertion: _____

12. Does you child wear glasses? (circle one) YES NO
    Date of last eye exam: _____ Name of Dr.: _____
    Visual problems found: _____
    Concerns: _____

13. Is bedwetting a problem? (circle one) YES NO
    Does your child have wetting accidents during the day? (circle one) YES NO
    Does your child have occasional accidents with bowel movements?(circle one) YES NO
    If yes to either, specify time: _____

14. Birth Weight: _____

15. Were there any complications before, during, or immediately after birth?(circle one) YES NO
    If yes, explain: _____

16. What age did your child: Walk alone? _____
Talk (2 word together)? _____
Daytime toilet trained? _____

17. Does any close relatives have a history of:
(√ and indicate relationship to this child)

Diabetes	_____	Cancer	_____
High Blood Pressure	_____	Anemia	_____
Seizures	_____	Sickle Cell Anemia	_____
Learning Problems	_____	Mental Retardation	_____
Birth Defect	_____	Heart Disease	_____

Other _____

18. Are there any concerns within the child's living situation that might affect learning?
_____
_____
_____

19. Please advise of any health (physical/ socio-emotional) issues not previously addressed concerning your child: _____
_____
_____

CONSISTENT WITH THE CONNECTICUT GENERAL STATUTE 10-104a, YOUR CHILD MUST HAVE A PHYSICAL EXAMINATION, INCLUDING A BLOOD TEST FOR ANEMIA, AND MANDATED IMMUNIZATIONS PRIOR TO SCHOOL ENTRY.

I UNDERSTAND IT IS MY RESPONSIBILTY TO ESTABLISH, WITH THE PHYSICIAN OF MY CHOICE, AN APPOINTMENT TO COMPLETE A PHYSICAL EXAMINATION, INCLUDING REQUIRED IMMUNIZATIONS, AND TO PROVIDE THE SCHOOL WITH THIS INFORMATION BEFORE MY CHILD WILL BE ALLOWED TO ATTEND SCHOOL.

CHILD'S NAME: _____

PARENT/ GUARDIAN SIGNATURE: _____

DATE: _____

(Office Use Only)
Name: _____

MARY R. FISHER ELEMENTARY SCHOOL
KINDERGARTEN REGISTRATION

HEALTH DEPARTMENT

Please check as each step is completed:

_____ Social/ Medical History is obtained

_____ Physical exam form given to parent

_____ Physical exam form completed

_____ Verification of immunization

_____ Special Needs care plan completed

_____ Vision and Audio screening performed

_____ Emergency Card completed

Student Name: _____

Grade | | | | |

Year | | | | |

Status | | | | |