# HEALTH RECORD REGISTRATION

| Student's Legal Last Name | | Student's Legal First Name | Middle Name | Other Legal Name (if applicable) | |
|---|---|---|---|---|---|
| | | | | | |
| ☐ Male | ☐ Female | Birthdate: / / | Place of Birth | | |
| Parent/Guardian Last Name | | Parent/Guardian First Name | Home Phone | Cell Phone | Work Phone |
| | | | | | |
| Parent/Guardian Last Name | | Parent/Guardian First Name | Home Phone | Cell Phone | Work Phone |
| | | | | | |
| Residence Address (street#, street name, apt.#) | | | City | State | Zip |
| | | | | | |

| Number of Children living at home | Child lives with: (Check appropriate box) | | | | |
|---|---|---|---|---|---|
| | ☐ Both Parents | ☐ Mother | ☐ Father | ☐ Guardian | ☐ Other: |

Please check appropriate response for each condition listed below:

| YES | NO | HEAD | AGE |
|---|---|---|---|
| | | Concussion | |
| | | Tendency to faint | |
| | | Convulsion | |
| | | Recurrent headaches | |

| YES | NO | EYE | | |
|---|---|---|---|---|
| | | Last Eye examination date: | | |
| | | Optometrist: | | |
| | | Glasses | ☐ Fulltime | ☐ Reading Only |
| | | Contacts | | |

| YES | NO | EAR, NOSE, THROAT AND MOUTH |
|---|---|---|
| | | Hearing Loss |
| | | Difficulty with speech |

| YES | NO | SPECIAL NEEDS | | | |
|---|---|---|---|---|---|
| | | Epilepsy: | Type: ☐ Grand Mal | ☐ Petit Mal | ☐ Other: |
| | | Diabetes: | Insulin Dependent? | ☐ Yes | ☐ No |
| | | Asthma: | If yes, is inhaler needed? | ☐ Yes ☐ No | |
| | | Bee Sting reaction other than mild local swelling | Epipen Needed? | ☐ Yes | ☐ No |
| | | Allergic reaction to medicine or food. If yes, please list: | | | |
| | | | | | |
| | | Heart Condition(specify): | | | |

***According to the Education Code, parents are required to inform the school their child is on routine medication.***

| Name of Medication(s): | | | |
|---|---|---|---|
| Medication(s) is taken at: | ☐ Home | ☐ School | ☐ Home and School |

***If medication is brought to school and/or carried on your student's property, proper paperwork is required and mandatory to have on file in health office. Please contact school health office for forms and information.***

List any special health problem or physical disability that should be brought to the attention of the school nurse or teacher: ____________________________________________________________________________

Family Doctor/Primary Care Provider: ____________________________________________________________

Please complete backside

**THIS IS A PERMANENT RECORD**

# DEVELOPMENT HISTORY

| **Name of Student:** |
|---|

| **Pregnancy with above-named child: (Check appropriate boxes, or fill in blanks)** | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Under doctor's care in month. | | | Measles during pregnancy: | | ☐ Yes | ☐ No | |
| 2. Medications used during pregnancy: | | | | | | | |
| 3. Illness or accidents during pregnancy: | | | | | | | |
| 4. Health during pregnancy: | ☐ Excellent | ☐ Good | ☐ Fair | Type of delivery: | ☐ Vaginal | ☐ Caesarean | |
| 5. Delivery Problems: | ☐ Forceps | ☐ Bleeding | | ☐ Breech | ☐ Other: | | |

| **Student:** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| **1. Condition at birth: (Check appropriate boxes, or fill in blanks)** | | | | | | | | |
| **Birth Weight**: | **Cry:** | ☐ immediate | ☐ delayed | **Color:** | ☐ pink | ☐ dusky | ☐ blue | |
| **Activity Level:** | | | **Injury:** | | | **Seizures:** | | |
| **Birth Defect(s):** | | | **Breathing problem(s):** | | | **Jaundice:** | | |
| **2. Childhood:** | | | | | | | | |
| **Illnesses:** | | | | **Accidents:** | | | | |
| | | | | | | | | |
| **3. Feeding and Diet: (Check appropriate boxes, or fill in blanks)** | | | | | | | | |
| **Weight Gain:** | ☐ slow | ☐ average | ☐ fast | **Appetite:** | ☐ good | ☐ poor | ☐ picky eater | ☐ eats moist foods |
| **Allergies:** | Infancy: | | | Present: | | | | |
| | | | | | | | | |
| **4. Sleep and Rest patterns: (Check appropriate boxes, or fill in blanks)** | | | | | | | | |
| **Average hours per night:** | | **Sleeps:** | ☐ quietly | ☐ restless | ☐ dreams | ☐ walks in sleep | | |
| | | | ☐ bed wetter | ☐ needs naps | ☐ rested after night's sleep | | | |
| **5. Developmental landmarks: (List AGE when he/she)** | | | | | | | | |
| Sat alone: | Crawled: | Walked: | | First tooth: | Fed self: | | | |
| Established bladder control: | | Bowed control: | | | | | | |
| **Speech** | First Word: | Phrases: | | Sentences: | | | | |

| **My child has had SPECIAL SERVICES in a previous school** ☐ Yes ☐ No | | | | | |
|---|---|---|---|---|---|
| **Please circle:** | Speech | Special Day Class | Resource Program | Psychological Testing | Adaptive Physical Education |
| | Other: | | | | |

Signature of Parent or Guardian    Relationship    Date

*If guardian, have guardianship papers been completed: Yes____ No____*

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**HS-9b (1/2020)**