

**CHICO UNIFIED SCHOOL DISTRICT
1163 E. 7th Street, Chico, CA 95928**

SCHOOL: _____ PHONE: _____ FAX: _____

REGISTRATION HEALTH RECORD

Name of Pupil _____ Sex _____ Date of Birth _____ Place of Birth _____

Pupil's Address _____ Home Phone _____

Father's Name _____ Daytime Phone _____ Cell/Pager _____

Mother's Name _____ Daytime Phone _____ Cell/Pager _____

Guardian's Name _____ Daytime Phone _____ Cell/Pager _____

Number of children living at home _____ Child lives with: Both parents ___ Father ___ Mother ___ Guardian ___

Please check appropriate response for each condition listed below:

Yes	No	Head	Age	Yes	No	Eye
		Concussion				Glasses Full time <input type="checkbox"/> Reading Only <input type="checkbox"/>
		Tendency to faint				Contacts
		Convulsions		Yes	No	Ear, Nose, Throat, Mouth
		Recurrent headaches				Hearing loss
						Difficulty with speech

Yes	No	Special Needs
		Epilepsy: Type: Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other <input type="checkbox"/>
		Diabetes: Insulin Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>
		Asthma: Inhaler Needed? Yes <input type="checkbox"/> No <input type="checkbox"/>
		Bee Sting reactions other than mild local swelling EpiPen Needed? Yes <input type="checkbox"/> No <input type="checkbox"/>
		Allergic reaction to medicine or food. If so, please list:
		Heart Condition (specify):

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

Name of Medications(s): _____

Medication is taken at: Home School Home and School **If medication is brought to school and/or carried on your student's person, proper paper work 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: _____

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: _____

PLEASE TURN OVER AND COMPLETE PAGE 2

Signature of Parent or Guardian Relationship Date

If guardian, have guardianship papers been completed: Yes ___ No ___

DEVELOPMENTAL HISTORY – Page 2

Name of Pupil: _____

Pregnancy with above-named child: (Mark appropriate word, or fill in blank)

- 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: _____

Pupil:

- 1) Condition at birth: Birth weight _____ Cry: immediate ___ delayed ___ Color: pink ___ dusky ___ blue ___
Activity level: _____ Injury: _____ Seizures: _____
Birth defects: _____ Breathing problems: _____ Jaundice: _____
- 2) Childhood illnesses: _____ Accidents: _____
Describe: _____
- 3) Pupil's feeding and diet: Weight gain: slow ___ average ___ fast ___
Appetite: good ___ poor ___ picky eater ___ eats most foods ___
Allergies: Infancy: _____ Present: _____
- 4) Pupil's sleep and rest patterns: 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 _____ bowel control _____ Speech: first word _____ phrases _____ sentences _____