Sagaponack Common School
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HEALTH REGISTRATION FORM

Name: _____ Date of Birth: _____
Last First Middle

Social Development:

1. Language child usually speaks at home _____
2. Is your child right handed? ☐ left handed? ☐
3. Does your child do simple household tasks? ☐ Yes ☐ No
4. Does your child prefer to socialize with peers or alone? (Circle one)
5. Do you consider your child overly shy? ☐ Yes ☐ No
6. Do you consider your child over-active? ☐ Yes ☐ No
7. Has your child ever had a sleeping problem? ☐ Yes ☐ No
8. Has your child ever had an eating disorder? ☐ Yes ☐ No

Physical Development:

1. Do you think your child is average in height? ☐ Yes ☐ No Weight? ☐ Yes ☐ No
2. Does your child fall frequently? ☐ Yes ☐ No
3. Does your child bump into objects around him/her? ☐ Yes ☐ No
4. Rate your child on the following skills compared with other children the same age (circle one):

Walking	Good	Average	Poor
Running	Good	Average	Poor
Throwing	Good	Average	Poor
Catching	Good	Average	Poor
Athletic Ability	Good	Average	Poor
Writing	Good	Average	Poor

Current Health Status: (Check if applicable)

____ Allergies _____ onset _____
____ Asthma, onset _____
____ Any pain or lumps in your groin? ☐ Yes ☐ No
____ Broken bones? Specify _____ Right _____ Left _____
____ Chest pain ____ High blood pressure _____
____ Chicken pox, when? _____
____ Convulsive disorder/seizure (due to high fever, etc.), onset _____
____ Diabetes, onset _____
____ Discharge from penis? ☐ Yes ☐ No
____ Epilepsy, onset _____
____ Frequent colds and/or sore throats
____ Frequent headaches
____ Has menstruation begun? ☐ Yes ☐ No If yes, month ____ year ____
____ Are periods painful? ☐ Yes ☐ No Regularly? ☐ Yes ☐ No
____ Hearing difficulties and/or infections
____ Operation (specify) _____
____ Pains in extremities or joints
____ Physical handicap (specify) _____
____ Pneumonia
____ Rheumatic fever, onset _____
____ Scarlet fever, onset _____
____ Scoliosis, onset _____
____ Serious injury, specify _____
____ Serious burns, specify _____
____ Skin conditions, specify _____
____ Special or poor eating habits
____ Speech difficulties
____ Tuberculosis, onset _____
____ Urinary conditions (specify) Pain _____ Burning _____ Blood _____
____ Vision – wears glasses? ☐ Yes ☐ No
Other (specify) _____

____ Currently under a physician's care? ☐ Yes ☐ No
Name of Physician: _____

____ Currently under a dentist's care? ☐ Yes ☐ No
Name of Dentist: _____

____ Medication (Please indicate name and dosage of any medication your child is taking)
_____

____ Ever been hospitalized? ☐ Yes ☐ No If yes, when? _____
Condition? _____

____ Is there anything else you would like to tell us about your child to help him/her to have a positive school experience? _____
_____
_____
_____

Family History:

1. Circle any of the following diseases that your child's parents, grandparents, aunts, uncles, brothers, sisters have had. (Also circle M to indicate maternal or P to indicate paternal.)

   Tuberculosis (M P) Diabetes (M P) Asthma (M P)
   Mental Illness (M P) Epilepsy (M P) Cancer (M P)
   Allergic Reactions (M P) To what substance? _____
   Inherited Diseases (M P) Other _____

2. Are the child's parents both in good health? ☐ Yes ☐ No

3. What is the general health of brothers and sisters? _____

Birth History:

1. Was the child adopted? ☐ Yes ☐ No

2. Normal pregnancy? ☐ Yes ☐ No

3. If pregnancy wasn't normal, please explain (spotting, toxemia, premature, illnesses, accidents, etc.):
   _____
   _____

4. If premature, how many weeks? _____

5. Any marks on baby? ☐ Yes ☐ No

6. Do any foods disagree with him/her? ☐ Yes ☐ No If yes, please explain: _____
   _____

7. Does he/she often have diarrhea? ☐ Yes ☐ No

8. Has constipation ever been much of a problem? ☐ Yes ☐ No

9. Are immunizations complete? ☐ Yes ☐ No

10. Was your child born with any congenital diseases or abnormalities? ☐ Yes ☐ No
    If yes, please explain (Sickle Cell Anemia, kidney disease, PKU, congenital hip, club foot?)
    _____

Emotional:

1. Is he/she doing well in school? ☐ Yes ☐ No
2. Does he/she get along well with peers? ☐ Yes ☐ No
3. Circle any of the following which your child has:

Nail biting	Irritable	Thumbsucking
Breath holding	Won't mind	Bad temper
Jealousy	Nightmares	Bedwetting

4. Other concerns: _____
   _____
5. How much time does your child spend watching TV each day? _____
   Favorite TV program? _____
6. Does he/she play alone? ☐ Yes ☐ No
7. Does he/she play quiet games? ☐ Yes ☐ No Active games? ☐ Yes ☐ No
8. Does he/she interact with peers? ☐ Yes ☐ No
9. Does your child participate in organized activities or take part in other classes?
   ☐ Yes ☐ No (Please explain) _____
10. Has your child ever experienced family moving? ☐Yes ☐No How many times? ____
11. Has your child ever lived with someone other than his/her parents? ☐ Yes ☐ No
    When? _____ With whom? _____
12. Has your child had a traumatic experience lately? ☐Yes ☐No If so, please explain:
    _____
13. Has your child ever experienced a death in the family? ☐ Yes ☐ No
    Whom? _____ When? _____
14. Has your child ever experienced a parent or other family member with a long illness?
    ☐ Yes ☐ No
15. Has your child had periods of sadness or depression? ☐ Yes ☐ No

_____ _____ _____

Signature of person completing form Relationship to child Date

Revised 9/10