Date ___________________________________

GIBBSBORO PALS
Gibbsboro, New Jersey

MEDICAL REGISTRATION FORM

Student's Name ____

Date of Birth ____________________________________ Sex: M ______ F _____

What was mother's due date? ____________________________

Birth Weight __________________

1. Does your child have any allergies? If yes, please explain where necessary.

   A. Medication No ____ Yes ____
   B. Foods No ____ Yes ____
   C. Environmental:
      1) seasonal or hay fever type allergy Yes ______ No ______
      2) house dust, grasses, trees, soaps, etc, Yes ______ No ______
      3) insect bites or stings Yes ______ No ______
      4) animals Yes ______ No ______
      5) Other ____

2. Has your child had any serious illness, injury or been operated on? If yes, please explain.
   No ____ Yes ____

3. Does your child have either a physical handicap or a chronic illness? If yes, please explain.
   No ____ Yes ____

4. Does your child take medication on a regular basis? If yes, please explain.
   No ____ Yes ____

5. Childhood disease history. If **YES**, please give approximate dates.

   A. Chicken Pox ____________
   B. Ear Infection ____________
   C. Asthma ____________
   D. Kidney Infection ____________
   E. Frequent respiratory infections ___________
   ____
   F. Other ___________________________________
   ____

6. Were there any problems for mother and/or baby during pregnancy, delivery, or shortly after birth?
   No ____ Yes ____

CONTINUED ON BACK – PLEASE COMPLETE

7. Did your baby require oxygen at the time of birth or shortly after?
   No ____ Yes ____

8. Are there any nutrition problems?
   No ____ Yes ____

9. Does your child have now or has he/she ever had any of the following behaviors?

Stuttering	_____	Excessive crying	_____
Bedwetting	_____	Nervous habits	_____
Nightmares	_____	Fears	_____
Nail biting	_____	Temper tantrums	_____
Aggressiveness	_____	Other: ________________________________	

10. Which hand does your child use? __________________
11. Has your child been examined by a dentist? Yes ______ No ______
12. Has your child been examined by an eye doctor? Yes ______ No ______
13. Does your child wear glasses? Yes ______ No ______
14. Family health history:
    Indicate relationship (i.e.: grandparents, aunts, uncles, as well as mother and father)

Diabetes	___________________	Thyroid problems	______________________
Heart Disease	___________________	Seizures	______________________
Asthma/Allergies	___________________	Obesity	______________________
Arthritis	___________________	Cancer	______________________
High Blood Pressure	__________________	Mental Illness	______________________

15. Does your child have any behaviors that would make you suspicious of either a hearing or vision problem?
    No ____ Yes ____

16. Please feel free to comment on anything about your child that you consider relevant to his/her adjustment to PALS. Do you have any concerns regarding your child's health?