

Date _____

GIBBSBORO SCHOOL
Gibbsboro, New Jersey

NURSE'S OFFICE 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 _____

E. Frequent respiratory infections _____

B. Ear Infection _____

C. Asthma _____

F. Other _____

D. Kidney Infection _____

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 school. Do you have any concerns regarding your child's health?