Date _____

GIBBSBORO SCHOOL

NURSE'S OFFICE REGISTRATION FORM

Student's Name _____

Date of Birth _____ Gender: M _____ F _____

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 medical condition? If yes, please explain.

   No ____ Yes _____

4. Does your child take medication on a regular basis? If yes, please explain.

   No ____ Yes _____

   Does your child take any medications as needed (inhaler, nebulizer, etc.)?

   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	_____
Anxiety	_____		
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?