

William E. Norris School

Registration and Health Record

Child's Name _____

Last
First
Middle
Nickname

Date of Birth _____ Place of Birth _____ Sex _____

Home Address _____ Phone # _____

Parent/ _____ Employer _____
Father: Last name First name

Business Address: _____ Phone# _____ Cell _____

Parent/ _____ Employer _____
Mother: Last name First name

Business Address: _____ Phone# _____ Cell _____

Please list home address and phone number of a parent if it is different from home address above.

Parent/ Guardian Name _____
 Address _____ Phone _____

Give the names and dates of birth of all siblings.

Give the names and relationships of other people living in the home.

If living other than with parents, this is to be filled out:

Living with _____

Last name
First name
Relationship

For office use only

Grade _____ Lasid _____ Sasid _____
 Birth Certificate Checked _____ Other _____

HEALTH HISTORY

1. Is this child under the care or observation of a doctor? _____

Does he/she take any medications regularly? _____ What? _____

Does he/she take it during school hours? _____

If so, please consult the school nurse.

Does this child have any allergic reactions? _____ To What? _____

2. Was there anything unusual about the pregnancy with this child?

Did he/she require any special medical care or hospitalization at birth or during the first month after birth? _____

Has this child ever been in the hospital or been seriously ill at home? Yes _____ No _____

If yes, explain _____

3. Are there any other aspects of your child's physical condition which you feel may limit his/ her participation in school activities? Yes _____ No _____

If yes, please explain _____

4. Your child began walking at age _____

Your child was toilet trained at age: _____ for day _____ for night _____

5. Language spoken at home _____
primary secondary

DEVELOPMENTAL HISTORY

Has your child ever had a vision exam or treatment? Yes _____ No _____

When _____ By Whom _____ Results _____

Does this child:

1. Seem to have difficulty seeing small lines or pictures? Yes _____ No _____

2. Seem to have a problem seeing things far away? Yes _____ No _____

3. Squint? Yes _____ No _____

4. Wear glasses? Yes _____ No _____

5. Have eyes that turn in? Yes _____ No _____

6. Have eyes that turn out? Yes _____ No _____

7. Eye problems? Explain Yes _____ No _____

Has your child ever had any ear/hearing exams or treatments? Yes _____ No _____
When _____ By Whom _____ Results _____

Does this child:

1. Seem to have difficulty hearing? Yes _____ No _____
2. Turn up the TV louder than other family members? Yes _____ No _____
3. Jump or appear to be more startled than others if there is a sudden noise?
Yes _____ No _____
4. Seem to hear you if you talk in a whisper? Yes _____ No _____
5. Make you talk loudly or repeat frequently? Yes _____ No _____
6. Is there a family history of hearing problems? Yes _____ No _____
7. Ear Infections? Yes _____ No _____

When your child talks to you, does he/she use: single words (), 2-3 word phrases (), sentences ()

- | Does your child: (Mark one) | Yes | Sometimes | No |
|--|-----|-----------|-----|
| 1. Speak so you can understand him/her? | ___ | _____ | ___ |
| 2. Speak so other adults understand him/her? | ___ | _____ | ___ |
| 3. Speak so other children understand him/her? | ___ | _____ | ___ |
| 4. Does your child enjoy listening to stories? | ___ | _____ | ___ |
| 5. Can he/she re-tell the story? | ___ | _____ | ___ |
| 6. Does your child follow directions? | ___ | _____ | ___ |

If this child does not talk, does he/she: (Mark one)

- | | | | |
|---------------------------------|-----|-------|-----|
| 1. Make any sounds? | ___ | _____ | ___ |
| 2. Use gestures to communicate? | ___ | _____ | ___ |

Do you think your child has a problem:

- | | | | |
|---|-----------|----------|---------------|
| 1. Making sounds? | Yes _____ | No _____ | Example _____ |
| 2. Putting words together? | Yes _____ | No _____ | Example _____ |
| 3. With the way his/her voice sounds? | Yes _____ | No _____ | Example _____ |
| 4. Repeating sounds or words too often? | Yes _____ | No _____ | Example _____ |

HOME HISTORY

1. What do you like about your child?

2. Does he/she prefer to play alone or with others? _____

3. Does he/she play well with other children? _____

4. How does this child differ from his/her brothers and sisters?

_____ 5. Is your child unusually active? _____ Unusually passive? _____ 6. Do you have any special concerns about your child, i.e. unusual fears, sleeping, eating, discipline problems? _____

7. What does your child have for responsibilities at home? (dressing, putting toys away, etc.)

8. Has your child ever been to a nursery school, day care center, or other program? _____
Where? _____ When (how long?) _____
If so, what was this experience like for your child? _____

9. What do you feel is important for your child to gain from his/her preschool/ kindergarten experience?
Please number the following in order of importance to you.

- _____ Getting along with others
- _____ Self-confidence
- _____ Creativity
- _____ Learning to speak up for oneself
- _____ Responsibility
- _____ Readiness skills for reading, writing, math, etc.
- _____ Communication skills
- _____ Physical skills
- _____ Other _____

10. Does your child display any special interests such as music, art, books, performing for others, leading other children, engaging in physical activities?

11. Has your child had any unsettling experiences, i.e. divorce, separation, death in family, illness? _____

12. Is there anything further that you would like to mention about your child? _____

Date _____ Completed by _____
