

# William E. Norris School

## Registration and Health Record

Child's Name \_\_\_\_\_  
*Last First Middle Nickname*

Date of Birth \_\_\_\_\_ City/State of birth \_\_\_\_\_ Sex \_\_\_\_\_

Home Address \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/ \_\_\_\_\_ Employer \_\_\_\_\_  
*Father:*

Business Address: \_\_\_\_\_ Phone# \_\_\_\_\_ Cell \_\_\_\_\_

Parent/ \_\_\_\_\_ Employer \_\_\_\_\_  
*Mother:*

Business Address: \_\_\_\_\_ Phone# \_\_\_\_\_ Cell \_\_\_\_\_

Parent email: \_\_\_\_\_

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

Parent/ Guardian Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

email: \_\_\_\_\_

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Names and dates of birth of all siblings.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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*

## HEALTH HISTORY

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

Does he/she take any medications regularly? \_\_\_\_\_ List medications: \_\_\_\_\_

If yes, why? \_\_\_\_\_

Does he/she take it during school hours? \_\_\_\_\_

If yes, 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 since birth? \_\_\_\_\_

At what

age? \_\_\_\_\_ Why? \_\_\_\_\_

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
- \_\_\_\_\_ Readiness skills for reading, writing, math, etc.
- \_\_\_\_\_ Learning to speak up for oneself
- \_\_\_\_\_ Responsibility
- \_\_\_\_\_ Creativity
- \_\_\_\_\_ 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 \_\_\_\_\_

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