Haddon Heights School District

SERVING THE COMMUNITIES OF HADDON HEIGHTS, BARRINGTON AND LAWNSIDE

HADDON HEIGHTS ELEMENTARY SCHOOLS
REGISTRATION FORM

Name_____
First **Middle** **Last**

Name used in school_____

Address_____ **Home Phone**_____

Date of Birth_____ **Sex: Male**_____ **Female**_____**Grade**_____

Birth City _____ **Birth State** _____ **Birth Country** _____

Race and Ethnicity: (Please check all that apply)

Hispanic or Latino_____ **Asian**_____ **African American**_____ **Caucasian**_____
American Indian _____ **Pacific Islander**_____

Family Doctor_____**Phone**_____

Child's Doctor (if different from above)_____**Phone**_____

Parent_____

E-mail_____

Cell phone_____

Employer_____**Occupation**_____

Employer's Telephone No. _____

Parent_____

E-mail_____

Cell phone_____

Employer_____**Occupation**_____

Employer's Telephone No. _____

Marital Status of Parents: Married_____ Separated_____ Divorced_____ Single_____
Civil Union____ Mother Deceased_____ Father Deceased_____

Child lives with: Both parents_____ Mother_____ Father_____ Other-Specific _____

Other children in household?

Name	Birthday	Grade	School

Other residents living in the home and relationship_____

Legal Guardian (if other than parent)
_____

Are there any custody issues or restraining / protective orders? Yes _____ No_____
Type? Please attach a copy

_____

Alternate names and telephone numbers to call if parent is not at home:

1._____

2._____

Did your child attend nursery school / pre-school? (Kindergarten only)
If so, where_____

May we contact your child's previous school? Yes_____ No_____

Is your child: right handed_____ left handed_____ not sure_____

Has your child ever been evaluated by a Child Study Team?
Yes_____No_____

Does you child have an IEP? Yes_____ No_____

Does your child have a 504 plan Yes_____ No_____

Has your children ever been retained Yes____ No_____ What grade_____

Would you like to speak with school personnel regarding your child's readiness?
_____

For office Use only:

Date Form Submitted	
Birth Cert Received	
Proof of Residence	
Immunization Up To Date	
Physical	

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Medical History Form

Parent/guardian to complete this form and return it to the nurse's office

Student's Name_____ D.O.B._____
Doctor's Name_____
Date of last physical exam_____

Has your child had any of the following:

Illness	No	Yes	Date of Illness
Chickenpox			
Measles			
Mumps			
German Measles			
Lyme Disease			
Frequent Strep. Infection			
Scarlet Fever			
Rheumatic Fever			
Mononucleosis			
Hepatitis (type)			

Does your child have any of the following :

	No	Yes	Explain
Nosebleeds			
Seizures			
Diabetes			
Asthma			mild or severe
Allergy to foods			food & reaction
Allergy to medication			med. & reaction
Bee sting allergy			reaction
Seasonal allergies			season & symptoms
Vision problem			
Hearing problem			
Tubes in ears			
Muscle problems			
Broken bone history			
Past surgery			
Other medical problems			

Has your child ever been hospitalized? **No**_____ **Yes**_____
If yes, please indicate date and reason_____

Is your child currently on any daily medication? **No**_____ **Yes**_____
If yes, please give name of medication, amount and reason. If any medication needs to be given during school hours a consent form will need to be completed by the parent and doctor ordering the medication (including over the counter medications)._____

I give permission for health concerns information to be shared with appropriate staff having contact with my child

No_____ **Yes**_____

Parent/guardian signature

_____

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Child Health Assessment
To be filled out by MD

Name:_____ DOB: _____
Address_____
Phone: _____
Health history and medical information pertinent to routine child care emergencies:
_____
Allergies / Reactions:
_____
PHYSICAL EXAM Date: _____
Wt Readings from Last Encounter: **Ht Readings from Last Encounters:** **BP Readings from Last Encounter:**
_____ _____ _____

HEENT: _____
Teeth: _____
CV / Resp:_____
GU/Breast: _____
Abdomen:_____
Ext/Back: _____
Skin/Lymph: _____
Neurological: _____
Developmental: _____

Immunization History – Document or Attachment	
DTaP	
IPV	
Hib	
Hepatitis B	
Hepatitis A	
Pneumococcal Conjugate	
MMR	
Varicella	
Influenza	
Menectra	
Tdap	

Screening Test Summary if Done
Lead: _____
Anemia (Hgb/Hct): _____
Urinalysis (UA): _____
Hearing: _____
Vision: _____
Date of Last Dentist Exam:_____
Medications: Name, Route, Frequency—If medication to be given in school need separate med form

_____

MD Signature_____ Date_____

Office (Name / Address Or Stamp) _____

_____

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Preschool Registration Checklist

Please ensure that the following is submitted to Atlantic Avenue Elementary School Secretary by April 28, 2017 in order to enroll your child in the preschool class.

☐Copy of birth certificate

☐Copy of your child's immunization record

☐Proof of residency (a driver's license, tax or utility bill, etc) for non-staff applicants

☐Copy of recent physical

If child has had a physical in the last six months, this will be acceptable. If not, please furnish it to the school nurse before school begins in September.