BLAIRSTOWN ELEMENTARY SCHOOL – PRE-SCHOOL REGISTRATION FORM

Student's Name: _____ A.M/P.M./FULL DAY (circle one)
Last First Middle

Date of Birth: _____ MALE/FEMALE (circle one)

Place of Birth: (City & State) _____

Nationality: Asian ___ Black ___ Hispanic/Latino ___ American Indian/Alaskan ___
Hawaiian/Pacific Islander ___ White ___ Multi-Racial ___
(check all that apply)

Mailing/Street Address: _____
_____

Township of Residence: ( ) Blairstown ( ) Hardwick ( ) Other (Check one)
Is your child allergic to Peanuts/Nuts? ( ) Yes ( ) No

Primary Language spoken at Home:_____ Other Language Spoken Fluently: _____

Student Resides with: Mother & Father Mother Only Father Only
Mother & Stepfather Father & Stepmother Grandparent(s) (circle one)

FATHER'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone Number	
Cell Phone Number	
Email	
Employer	
Employer's Address	
Employer's Phone Number	
List any Specific Skill, Talent, Interest	

MOTHER'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone Number	
Cell Phone Number	
Email	
Employer	
Employer's Address	
Employer's Phone Number	
List any Specific Skill, Talent, Interest	

over

STEP-PARENT'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone Number	
Cell Phone Number	
Email	
Employer	
Employer's Address	
Employer's Phone Number	
List any Specific Skill, Talent, Interest	

SIBLING INFORMATION

NAME	RELATIONSHIP	DATE OF BIRTH	GRADE

TRANSFERRING FROM

Name of School	
Address of School	
Phone Number of School	

LOCAL EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS)

Name	Relationship	Address	Telephone Number

Physician

Name: _____

Address: _____

_____

Telephone Number: _____

School Use Only

Date Entered: _____ Date Records Requested:_____ Date Received: _____

Birth Certificate: _____ Immunizations Up – to – Date: _____

HEALTH HISTORY

	Pregnancy, Labor & Delivery	Yes	No	Comments
1.	Any Illness of mother during pregnancy			
2.	On any medications (other than iron or vitamins)			
3.	RH factor problems			
4.	Premature or late birth			
5.	Delivery problems (long labor, needed oxygen, etc.)			
6.	Birth weight			
7.	Problems after birth			

	Growth & Development	Age
1.	Sat up alone	
2.	Walked alone	
3.	Used two to three words together	
4.	Toilet Trained	
5.	Activity level	

MEDICAL

1. Local Hospital Preferred: _____

2. Previous medical evaluations (orthopedic, neurological, psychiatric, vision, hearing, etc.)
   _____

Illness, Injury, and Other Health Conditions

Disease	Date	Disease	Date	Disease	Date
Chicken Pox		Smallpox		Tuberculosis	
Measles		Whooping Cough		Meningitis	
German Measles		Diphtheria		Pneumonia	
Mumps		Polio		Hepatitis	
Scarlet Fever		Rheumatic Fever			

Frequent: Earaches: _____; Colds: _____; Sore Throats: _____; Cough: _____

Other Health Conditions:

Allergies (please specify type): _____
Asthma: _____
Colic: _____
Convulsions: _____
Diabetes: _____
Heart Trouble: _____
Eye Problems (glasses, etc): _____
Urinary or bowel problems: _____
Other: _____
Hospitalizations: _____
Medications (on any at present): _____