



# BLAIRSTOWN ELEMENTARY SCHOOL - REGISTRATION FORM



Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

                    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                      Bus Student: ( ) Yes ( ) No

Is your child allergic to Peanuts/Nuts? ( ) Yes   ( ) No

Would it be a hardship if your child is placed in a Peanut/Nut Free Class? ( ) 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	

**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	

Please check any of the programs or plans below that your child had at his/her former school.

Speech/Language ( )    Remedial Reading ( )    Remedial Math ( )    IEP ( )    504 Plan ( )  
English as a Second Language (ESL) ( )    Gifted & Talented Program ( )

**LOCAL EMERGENCY CONTACT INFORMATION (OTHER THAN PARENTS)**

Name	Relationship	Address	Telephone Number

**Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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School Use Only

Date Entered: \_\_\_\_\_ Date Records Requested: \_\_\_\_\_ Date Received: \_\_\_\_\_

Teachers: Homeroom \_\_\_\_\_ Reading: \_\_\_\_\_ Math: \_\_\_\_\_

Birth Certificate: \_\_\_\_\_ Immunizations Up - to - Date: \_\_\_\_\_

## **HEALTH HISTORY**

	<b>Pregnancy, Labor &amp; Delivery</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
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			

	<b>Growth &amp; Development</b>	<b>Age</b>
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: \_\_\_\_\_