Blairstown Elementary School

2010 - 2011 Pre-First Registration Form

PREFIRST SCREENING FOR SEPTEMBER 2010 for Blairstown Elementary School will be held on Saturday, March 13, 2010, and Saturday March 27, 2010, for all pupils entering pre-first (kindergarten) in September, 2010.

Please call Eileen at 908-362-6111 x109 for a screening appointment.

Registration information needed:

1) Child's birth certificate with the **raised seal** (5 years of age by October 1, 2010)

2) Signed doctor's certificate of immunization against the following:

DPT - 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses
Polio - 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses
Measles - 2 doses of a live Measles-containing vaccine
Mumps - 1 dose of live Mumps–containing vaccine
Rubella – 1 dose of live Rubella –containing vaccine
Varicella - 1 dose on or after first birthday
Hepatitis B - 3 doses

PLEASE RETURN THE COMPLETED REGISTRATION FORM, IMMUNIZATION RECORDS, AND BIRTH CERTIFICATE TO THE MAIN OFFICE BEFORE YOUR SCREENING APPOINTMENT.

BLAIRSTOWN ELEMENTARY SCHOOL - REGISTRATION FORM

Pupil's Name: ____
Last First Middle

Date of Birth ___________Sex __________ US Citizen ( ) Yes ( ) No

Nationality: Asian_____ Black_____ Hispanic/Latino_____ American Indian/Alaskan_____
Hawaiian Pacific Islander_____ Multi-Racial______ White _____

Mailing/Street Address____ PO Box_______________

____

Township of Residents ( ) Blairstown ( ) Hardwick ( ) Other Bus Pupil: ( ) ( ) No

Primary Language Spoken at Home: _______________ Other Language Spoken Fluently_____________

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

FATHER'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone No.	
Cell Phone No.	
Employer	
Employer's Address	
Employer's Phone No.	

MOTHER'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone No.	
Cell Phone No.	
Employer	
Employer's Address	
Employer's Phone No.	

STEP-PARENT'S INFORMATION

Name	
Residence/Mailing Address	
Home Telephone No.	
Cell Phone No.	
Employer	
Employer's Address	
Employer's Phone No.	

(OVER)

SIBLING INFORMATION

Name	Relationship	Date of Birth	Grade

TRANSFERRING FROM

Name of School	
Address of School	
Phone No. 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 ( )

EMERGENCY CONTACT INFORMATION - (OTHER THAN PARENTS)

Name	Relationship	Address	Telephone No.

PHYSICIAN

Name	Address	Telephone No.

DENTIST

Name	Address	Telephone No.

School Use Only

Date Entered_____________ Date Records Requested_____________ Date Received_____________

Teachers: Homeroom_________________ Reading_________________ Math_________________

Birth Certificate______________ Immunizations Up-to-Date_____________________________

HEALTH HISTORY

Pregnancy, Labor, and Delivery

		Yes	No	Comments
1.	Any illness of mother during pregnancy			
2.	On any medication (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 and Development

		AGE
1.	Sat up alone	
2.	Walked alone	
3.	Used two to three words together	
4.	Toilet trained	
5.	Activity level	

Medical

1. 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____

Operations ____

Medications (on any at present) ____