Immunization Records Must Be Returned By
August 31

BLAIRSTOWN TOWNSHIP SCHOOL DISTRICT
1 Sunset Hill Road Post Office Box E
Blairstown, New Jersey 07825
908-362-6111 - Fax:908-362-5989
www.blairstownelem.net

Dr. Patrick Ketch, *Superintendent* Colleen Silvestri, *Principal*
Matthew Herzer, *Business Administrator* Dr. Alyssa Emili, *Supervisor of Special Services*

Developmental History

Name:_____
Last Name First Name Middle Initial/Name

Address:_____
Street City State Zip

Father's Name:_____ Mother's Name:_____

Date of Birth:_____

Birth History
Length of Pregnancy:_____

Did you have any complications during the pregnancy? _____ Yes _____ No

If yes, please describe:_____

Child's birth weight:_____ length:_____

List any complications immediately after birth:_____

At what age did your child: sit alone_____ walk alone_____ first word_____
Toilet trained: bowel_____ bladder_____

List all daily medications and reason for taking:_____

List all allergies:_____

_____ My child is currently being desensitized

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Date of complete eye examination:_____

Glasses/Contacts:_____ Please check Reading_____Distance_____ Both_____

Date of complete hearing evaluation:_____

Please check all that pertain to your child and indicate age or date:

Check box:	**Name:**	**Date or Age:**	**Check box:**	**Name:**	**Date or Age:**
	Convulsive disorder			Eczema	
	Pneumonia			Bronchitis	
	Wheezing Asthma/RDA			Frequent Sore Throat	
	Tendency to Bleed Easily			Cardiac History	
	Ear Infections			Phys. Ed Exempt	

Please list any operations/hospitalizations/serious injuries:_____

_____

Any Additional Information:_____