

LITTLE SILVER SCHOOLS

Little Silver, NJ

Name _____

Health Questionnaire and Developmental History

Does your child have any of the following health conditions now or in the past?

Yes No Explain

Asthma			
Cardiac problems			
Car sickness			
Chronic ear infections			
Chicken pox			
Concussion			
Congenital condition (Specify)			
Diabetes			
Environmental allergies			
Fractured bones			
★ Wears orthopedic device (splint, etc.)			
Frequent headaches			
Head injury			
Hearing problem			
★ Wears hearing aid			
Hives			
Lyme disease			
Migraine headaches			
Seizure disorder			
Sinus infections			
Speech problem/concern			
Strep throat			
Urinary/bowel problems			
Vision problem			
★ Wears glasses or contact lenses (Circle one)			
Other			

1. Does your child have a **life-threatening allergy** (requires an EpiPen) to the following:

	Yes	No	If yes, which one(s)?
Foods			
Insects			
Other			

2. Does your child have any other allergies? Yes No

If yes, please specify type of allergy and reaction (hives, etc.):

3. Does your child take any medications either daily or as needed? Yes No

If yes, please list name of medication, reason for use and how often child takes the medication:

(OVER)

4. Has your child had any serious illness, injury or surgery? Yes No
If yes, please give details and date(s) of illness, injury, hospitalization or surgery:

5. **Birth Data** Full-term _____ Premature _____ (weeks)
Birth weight _____ Apgar score (if known) _____
Please indicate any difficulties during pregnancy or birth: _____

6. **Developmental Data:** Please give approximate ages that your child accomplished the following:

Sat up _____ Walked _____ Talked _____
Toilet trained _____
Left or right handed? _____ Established when? _____

7. Check any of the following patterns that you have observed in your child:
Easily frustrated _____ Completes tasks slowly _____
Exhibits aggressive behavior _____ Shyness _____
Talks a lot _____ Temper tantrums _____ Moody _____
Short attention span _____ Overly active _____
Difficulty communicating needs and wants _____
Other (please specify) _____

8. Has your child ever qualified or been enrolled in a specialized program? Please check all that apply:

Early intervention (please specify) _____
Pre-School _____ Speech _____ Second Language _____
Gifted and Talented _____ Other (please specify) _____

9. Has your child ever had an IEP _____ or 504 Plan _____?

10. Has your child ever received any private therapies? If so, please specify:

11. Do you have any concerns about your child's developmental behavior or emotional well-being that the school should be aware of? _____

12. Do you have any other concerns that you would like to share with us? _____

Student Release Authorization:

In the event that the school is unable to contact the parent/guardian, I authorize that my child may be released to the person(s) listed below:

Name and Relationship to Child Home and Cell Phone Numbers

Name and Relationship to Child Home and Cell Phone Numbers

Parent/Guardian Signature _____ Date _____

Sharing of Information:

I acknowledge that the information noted above may be shared with school staff members on a need-to-know basis for the safety and well-being of my child.

Parent/Guardian Signature _____ Date _____

PRESCHOOL PHYSICIAN'S EXAMINATION FORM

The physical examination must be completed before entering preschool. This examination must be done no more than 365 days prior to entry and must state what, if any, modifications are required for full participation in the school program.

Child's Name _____ Date of Birth _____

Address _____ Phone: _____

History and date of serious illness, injury, surgery, etc. _____

Does child require any of the following (please check all that apply): glasses _____ hearing aid _____

Corrective shoes _____ other _____

Is child presently taking any prescribed medication? If so, please explain: _____

Physical examination: WT _____ HT _____ BP _____ Heart _____ Lungs _____

Eyes _____ Ears _____ Nose _____ Throat _____ Skin _____

Orthopedic _____ Abdomen _____ Speech _____ Lymph nodes _____

General appearance _____

History (give dates where applicable): Asthma _____ Allergies (type) _____

Chicken Pox _____ Drug allergies _____ Hernia _____

Lyme disease _____ Meningitis _____ Mononucleosis _____ Pneumonia _____

Seizure disorder _____ Strep _____ Other _____

Immunizations: The following vaccines **are REQUIRED**. You must supply **month, day, and year**. (A copy of immunization record may be attached)

DPT: (4 doses required) (1) _____ (2) _____ (3) _____ (4) _____ (5) _____

OPV or IPV (3 doses required-indicate which): (1) _____ (2) _____ (3) _____

MMR (Measles, Mumps, & Rubella-1 dose required on or after first birthday): _____

HIB: (one dose after first birthday) (1) _____ (2) _____ (3) _____ (4) _____

Hepatitis B: _____
(1) _____ (2) _____ (3) _____

Varicella: (one dose after age 1 or proof of disease immunity) _____

Pneumococcal (PCV) Vaccine (on or after 1st birthday) _____

Influenza vaccine (required annually): _____ (administered between September 1-December 31)

Optional Vaccines:

Hepatitis A: (1) _____ (2) _____

Mantoux Tuberculin test: Date: _____ Result: _____

DATE OF EXAMINATION: _____

SIGNATURE OF PHYSICIAN/CNP: _____

PRINTED NAME OF PHYSICIAN/CNP: _____

LITTLE SILVER SCHOOLS

New Student Information Form

Pupil's Name _____ Grade _____
Last First Middle

RESIDENT STATUS AND EMERGENCY CONTACT INFO

Please select ONE: a. Owns a Home: _____ b. Rents/Leases: _____ (You must provide a current lease agreement each year prior to school starting.) c. Eligible for domicile waver - Lives with _____ (must complete Domicile Waiver)

Student resides with (please circle): Both Parents Guardian #1 Guardian #2 Other (please specify) _____

Emergency Contact Name : _____ Relation: _____ Cell Phone: _____
(Not a Parent)

CUSTODY INFORMATION (Please complete this section if student does NOT reside with both parents)

Legal, court awarded custody/guardianship is held by: _____ both parents jointly _____ Parent 1 _____ Parent 2 _____ Guardian(s)

Name: _____ Relationship: _____

Unless denied by court order, both parents are entitled by law to receive school mailings. If applicable, please indicate the name/address to which duplicate mailings are to be sent:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

IMPORTANT: You will be asked to provide a copy of your custody agreement prior to your child starting school in the fall.

SPECIAL CIRCUMSTANCES

Please describe any custody or residential circumstances that may exist. Please provide appropriate documentation for these circumstances prior to student attendance.

The Education Foundation of Little Silver and the Little Silver PTO are our parent organizations that support the schools in a variety of ways such as purchasing technology, providing cultural arts assemblies, providing teacher grants, assisting the district with the cleaning protocols necessary due to COVID, to name just a few. Normally, representatives from these groups would be with us today to collect your email address for future events, however, again, due to COVID they are not able to join us. Please complete the form below if you are willing to give us permission to share your email address with them.

I give Point Road School permission to share my email address(es) with the EFLS and LSPTO.

Signature: _____ Date: _____

Form Completed by (PLEASE PRINT) _____

Signature: _____