

FAIRHAVEN PUBLIC SCHOOLS
Registration and Health History Form

Entering Grade _____

Name _____
First FULL Middle Last

Gender: M F Date of Birth ____/____/____ City/Town of Birth _____

Home Address _____

City/ Town _____ Zip _____ Home Phone _____
Unlisted: Yes No

Email: _____

Mailing Address, if different: _____

With whom does the child reside? (Primary caregivers) _____

Relationship: _____

Mother's Name: _____ Address: _____

Mother's Cell: _____ Mother's maiden name: _____

Occupation: _____ Mother's Military Status: _____

Father's Name: _____ Address: _____

Father's Cell: _____ Occupation: _____

Father's Military Status: _____

If the child does not reside with both natural parents, is there a custody order that addresses any aspect of the child's school attendance or educational program? Yes No

Is there a restraining order in affect? Yes No **If yes, copies must be supplied to the school for our records**

Are the parents migrant workers? Yes No

Race: (please check) ____ Native American ____ Asian or Island Pacific ____ White ____ Black ____ Hispanic

Does your child have preschool experience? Yes No If so, where did he/she attend and for how long?

Has the student ever attended a Fairhaven school before? Yes No
Name of Fairhaven school _____ Grade _____

School last attended if not in Fairhaven _____

Are you aware of any special school/classroom accommodations needed for your child? Yes No

Is your child currently receiving or has he/she received any of the following specialized services:
____ Special Needs Program/IEP ____ State Ward (foster child)
____ 504 Plan Services ____ Free/Reduced Lunch
____ Title I

Other Children in Family:

Name _____ M or F Birthdate _____ Grade _____

Name _____ M or F Birthdate _____ Grade _____

Name _____ M or F Birthdate _____ Grade _____

Was this child's birth and early infancy free of trouble? Yes No

If no, please explain: _____

Has your child had any illness, surgery, accident or hospitalization of which the school should be aware? If so, please explain.

Does your child wear glasses? Yes No When is he/she required to wear these? _____

Does your child have any trouble hearing you? Yes No

Does your child have any allergies? (to food, medication, environmental, etc) Yes No If so, to what?

Is your child on any daily medication that will have to be administered in school? Yes No
If so, what medication and for what reason?

Does your child have a speech problem? Yes No

Is there any information regarding your child's health and habits that may be important, such as; fears, tantrums, interacting with other children? Yes No If yes, please explain:

Doctor's Name: _____

Dentist's Name: _____

Phone Number: _____

Phone Number: _____

All of this information will be held in strict confidence