St. Pius X Catholic School

Health Office Pupil Registration Form

Academic School Year
20____ - 20____

Student Information

Child's First and Last Name ______________________________ ☐ M ☐ F

Date of Birth ______________ Place of Birth ______________ Social Security# ______________

Ethnicity ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Address ______________________________

Home Phone ______________ Unlisted ☐ Y or ☐ N Email ______________

Transfer Information

Name of Previous School Attended/Address ______________________________

Last Day of Attendance ____________ Grade Completed ______ Reason for Leaving ______________

Family Information

Father's Name ______________________________ Home Phone ______________

Address/City/State/Zip ______________________________

Occupation ______________________________ Work Phone ______________

Mother's Name ______________________________ Home Phone ______________

Address/City/State/Zip ______________________________

Occupation ______________________________ Work Phone ______________

Guardian Name ______________________________ Home Phone ______________

Address/City/State/Zip ______________________________

Occupation ______________________________ Work Phone ______________

Sibling Name ______________ ☐ M ☐ F DOB ____________ Grade _____ School ______________

Sibling Name ______________ ☐ M ☐ F DOB ____________ Grade _____ School ______________

Sibling Name ______________ ☐ M ☐ F DOB ____________ Grade _____ School ______________

Sibling Name ______________ ☐ M ☐ F DOB ____________ Grade _____ School ______________

Medical Information

Physician's Name ______________________________ Phone ______________

Hospital Preference ______________________________

Special Information (please indicate if child has regular babysitter) ______________________________

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Other Information

If parent cannot be reached, please provide name and phone number of person to be called in an emergency:

Name

St. Pius X Catholic School

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Address & Telephone Number of the following:

Child's Physician ______________________________

Child's Dentist ______________________________

1. Is there a history of ear infection? ☐ yes ☐ no
2. If there is a history of ear infections, was your child's hearing checked? ☐ yes ☐ no
3. Has your child had tubes inserted in either or both ears? ☐ yes ☐ no
4. Has your child had a tonsillectomy and/or adenoidectomy? ☐ yes ☐ no
5. Does your child have food allergies? ☐ yes ☐ no

   If yes, please describe the allergens and symptoms. ______________________________
6. Does your child have seasonal allergies? ☐ yes ☐ no

   If yes, please describe the allergens and symptoms. ______________________________
7. Does your child have allergies to medication? ☐ yes ☐ no

   If yes, please describe the allergens and symptoms. ______________________________
8. Does your child have asthma? ☐ yes ☐ no

   If yes, please list all medications used.______________________________
9. Does your child receive regular medication? ☐ yes ☐ no

   If yes, please state. ______________________________
10. Has your child experienced any significant injuries or illnesses? ☐ yes ☐ no

    If yes, please describe. ______________________________
11. Has your child ever had a seizure? ☐ yes ☐ no

    If yes, please describe type and when.______________________________
12. Was your child born prematurely? ☐ yes ☐ no
13. Did your child have complications at birth? ☐ yes ☐ no

    If yes, please explain.______________________________
14. Has your child had a vision exam? ☐ yes ☐ no
15. Does your child wear glasses? ☐ yes ☐ no
16. Are there any other health concerns you would like the school to be aware of? ☐ yes ☐ no

    If yes, please describe. ______________________________

Parent/Guardian Signature ______________________________ Date ______________