



## STUDENT INFORMATION

NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

Parent or Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_ (home) \_\_\_\_\_ (office)

Alternate responsible relative or friend: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_ (home) \_\_\_\_\_ (office)

Family Doctor: \_\_\_\_\_ Tel: \_\_\_\_\_

Office Address: \_\_\_\_\_ Medical Plan No.: \_\_\_\_\_

Person to contact in emergency: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Tel: \_\_\_\_\_

Person who will call for child: \_\_\_\_\_

Siblings:

Name	Birth Date	Name	Birth Date

Has your child had previous experience away from home? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Do you think your child feels comfortable leaving mother? Yes \_\_\_\_\_ No \_\_\_\_\_

Special comments or instructions for the care giver: \_\_\_\_\_



Has your child any known health problems? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe: \_\_\_\_\_

Are there any indications of vision or hearing problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Has the child had any recent illness such as diarrhea or sore throat? Yes \_\_\_\_\_ No \_\_\_\_\_

Does the child have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list materials or products concerned: \_\_\_\_\_

Special instructions regarding food and materials to avoid and procedures to follow in the event of allergic attack, attached.

What are your child's eating habits?

Favorite foods: \_\_\_\_\_

Strong dislikes: \_\_\_\_\_

Religious or ethnic observances: \_\_\_\_\_

Has this child received any service from the public health nurse? Yes \_\_\_\_\_ No \_\_\_\_\_

Has this child received any immunization? Yes \_\_\_\_\_ No \_\_\_\_\_

Were immunization given at the health department or by the family physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Record of immunization as submitted by parent or guardian:

Protection for:	Dates
Diphtheria & Pertussis & Tetanus	
Poliomyelitis	
Rubeola (Measles)	
Rubella	
Mumps	

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**Official Use Only**

Date of Interview: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Date of Enrollment: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM DD YYYY

Signature of caregiver: \_\_\_\_\_

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