Evesham Township School District
Registration Signature Form 2023-2024

Name of Student: _____

Address: _____

Date of Birth: _____

Phone Number: _____

Registration Status:

- ☐ Pre-registered on Genesis and have all required documentation and forms for my registration appointment.
- ☐ Unable to register online, I will need to complete this step at my registration appointment. I am requesting a copy of all forms to be completed.

Other Children in Family: (If additional space is needed, please use the other side.)

Name (Oldest to Youngest)	Date of Birth (Month/Day/Year)	Place of Birth	Name of School/ Grade Attended

Name of Previous School/Preschool Attended:

Previous School/Preschool Attended	Complete Address (Town, County, State, Country)	Phone Number	Dates Attended

I hereby authorize the Evesham Township School District to investigate and confirm any and all statements made through my pre-registration and registration process. I am aware that if any statements concerning residency are false, I may be assessed the tuition for the aforementioned child and prosecuted to the full extent of the law.

Parent's Name: _____
(Please Print)

Parent's Signature: _____ Date: _____
(Please Sign in Ink)

Making the world a better place,
one student at a time

EVESHAM TOWNSHIP SCHOOL DISTRICT

HEALTH HISTORY and QUESTIONNAIRE
(to be completed by parent)

Name of Child _____ Date of Birth _____

Student's Health Status: past or present problems. *Check all that apply.*

_____ Epilepsy/Seizures
_____ Other neurological disorder
_____ Diabetes
_____ Asthma
_____ Kidney disorders
_____ Heart disease
_____ Orthopedic problems
_____ Fractures
_____ Sickle cell
_____ Mononucleosis
_____ Arthritis
_____ Cystic Fibrosis

_____ Eczema/dermatitis
_____ Other skin problem
_____ Hemophilia
_____ Meningitis
_____ Hepatitis
_____ Fainting
_____ Headaches, frequent
_____ Stomachaches, frequent
_____ Sore throat, frequent
_____ Constipation/Diarrhea
_____ Concussion/Head Injury

_____ Sleep problems
_____ Tonsillectomy
_____ Ear tubes inserted
_____ Other surgery
_____ Hearing problem
_____ Hearing aid/other device
_____ Vision problem
_____ Glasses/contacts
_____ Color blindness
_____ Speech problem
_____ Cancer

Premature birth? ☐ Yes ☐ No Newborn Complications ☐ Yes ☐ No

Medications that your child takes regularly: _____

Does your child have any restrictions on his/her activities? ☐ Yes ☐ No

Allergies

Food: Is your child allergic to any foods? ☐ Yes ☐ No
Explain any allergies: _____

Sting: Is your child allergic to any insect stings? ☐ Yes ☐ No
Explain any allergies: _____

Drug/Medication: Is your child allergic to any medications? ☐ Yes ☐ No
If yes, explain: _____

If your child has any other health condition or concerns, please describe below:

_____

_____

_____

Parent Name: _____
(Please Print)

Parent Signature: _____ Date: _____
(Please Sign in Ink)

EVESHAM TOWNSHIP SCHOOL DISTRICT

PHYSICAL EXAMINATION for PRESCHOOL THROUGH 5TH GRADE
(to be completed by physician)

Name of Child _____ Date of Birth _____

IMMUNIZATIONS: Please attach a copy of immunization record to this form.

MEDICAL HISTORY

Allergies _____
Asthma _____
Cardiac Disorders _____
Convulsive Disorders _____
Diabetes _____
Kidney Disorders _____
Neuromuscular Disorders _____
Congenital Defects _____

Surgeries or injuries: _____

Any other significant medical or emotional issues: _____

_____

EXAMINATION

Height _____ Weight _____ □ Male □ Female

BP / (/) Vision R 20/ L 20/ Corrected □ Yes □ No Hearing _____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Ears/Eyes/Nose/Throat		
Teeth		
Glands		
Heart		
Lungs		
Abdomen		
Hernia		
Genitourinary		
Skin		
Posture		
Nervous System		
Nutrition		
Speech		

General appearance _____

Does this child regularly take medication? _____

Cleared for all school activities (including physical education) ☐ Yes ☐ No
If no, reason/restrictions _____

_____

Comments or Recommendations _____

_____

_____ _____ _____
Doctor's Signature Date of Exam Office Stamp

EVESHAM TOWNSHIP SCHOOL DISTRICT

DENTAL CARE

Date_____

Child's Name_____ Grade_____

If your child has been to the family or pediatric dentist, please have them sign and return.

Name of Child: _____

Dentist's Name: _____
(Please Print)

Date of Last Visit: _____

☐ The child was examined and no treatment is necessary at this time. Continue with routine dental visits.

☐ The child was examined and treatment was completed for the following:

_____

Routine dental visits were recommended.

☐ The child was examined and is now receiving treatment for the following:

_____

Dentist's Signature: _____ Date: _____
(Please Sign in Ink)

EVESHAM TOWNSHIP SCHOOL DISTRICT

KINDERGARTEN PARENT QUESTIONNAIRE

Child's First and Last Name: _____ Date: _____

Nickname, if applicable (optional): _____

Please complete all sections below, as this information will be of great value to us to ensure a smooth transition to kindergarten.

ATTITUDE TOWARD SCHOOL (check all that apply)

☐ My child seems excited about kindergarten.
☐ My child appears ready for school.
☐ My child wants to stay home, but will come to school without getting upset.
☐ My child seems worried about starting kindergarten.

What do you think we should know about your child that would make his/her transition to kindergarten most effective?

_____

_____

PERSONALITY TRAITS (check all that apply to your child's HOME behavior)

☐ Accepts criticism
☐ Apprehensive
☐ Argumentative
☐ Complains easily
☐ Controlling
☐ Cries easily
☐ Dawdles
☐ Demanding
☐ Easily influenced by others
☐ Energetic
☐ Exhibits self-control
☐ Feelings get hurt easily
☐ Has temper tantrums
☐ Hesitant about new situation
☐ Moody
☐ Obeys slowly
☐ Outgoing
☐ Prefers company of adults
☐ Proceeds independently
☐ Puts things away
☐ Quiet
☐ Self-confident
☐ Sensitive
☐ Shy
☐ Stubborn
☐ Talkative
☐ Waits for help
☐ Has fears (describe): _____
☐ Other (describe): _____

READINESS SKILLS

My child attended preschool: (check one) ☐ yes* ☐ no
*If yes, where and when did they attend? _____

My child is able to: (check all that apply and add any information)
☐ Articulate (speak) clearly
☐ Enjoy being read to
☐ Finish what they start
☐ Know the difference between capital and lowercase letters
☐ Name basic geometric shapes (circle, square, triangle)
☐ Recognize numbers 0-10
☐ Recognize the letters of the alphabet
☐ Recognize their name: ☐ First ☐ Last
☐ Read books
☐ Read words
☐ Write their name: ☐ First ☐ Last

Comments about Readiness (optional):

_____

_____

_____

ACTIVITY LEVEL (check yes or no for each)

	YES	NO
My child is always active.	☐	☐
My child is generally calm.	☐	☐
My child is typically consistent with behavior.	☐	☐
My child is generally inconsistent with behavior.	☐	☐
My child is restless.	☐	☐
My child is slow in responding.	☐	☐
My child is unpredictable.	☐	☐

FINE MOTOR SKILLS

My child is: (check one) ☐ right-handed ☐ left-handed

My child is able to: (check all that apply)

☐ Tie shoes
☐ Use crayons/markers
☐ Use paints
☐ Use scissors
☐ Write letters of the alphabet
☐ Write sentences
☐ Write words
☐ Zip and button clothes

GROSS MOTOR SKILLS

My child is able to: (check all that apply)

☐ Climb
☐ Hop
☐ Jump
☐ Skip

ANY OTHER COMMENTS OR INFORMATION YOU WOULD LIKE TO SHARE: