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

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PRESCHOOL PARENT QUESTIONNAIRE

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

Nickname, if applicable (optional): _____

Having some information about your child will help us to make them feel more comfortable in the classroom as we begin preschool. If you are uncomfortable answering any question below, please leave it blank.

What are some of your child's favorite things to do?

_____

_____

What are some of your child's dislikes?

_____

_____

Does your child have any fears?

_____

_____

What techniques do you find work best to calm your child when they are upset?

_____

_____

What do you see as your child's greatest strengths?

_____

_____

What do you see as your child's greatest area of need?

_____

_____

What are some of your child's favorite movies/books/TV shows/games?

_____

_____

What are the important holidays your family celebrates?

Does your child use the restroom independently? Yes No

Children love to talk about their families! Knowing a little about the members of your family is helpful.

Who lives in your house? What are their occupations?

Does your family have any pets?

Are there any adults outside of those living in your home who have frequent contact with your child?

If there is anything else that you feel the preschool team should know about your child, please feel free to write it below.