WELCOME TO THE COATESVILLE AREA SCHOOL DISTRICT
A learning community rich in diversity and committed to excellence.

CENTRAL REGISTRATION
Grades K-12

The Coatesville Area School District has a central registration system for students enrolling in the district in grades K-12. Children are eligible for admission to kindergarten if they have attained the age of five (5) years on or before September 1st or for First Grade if they have attained the age of six (6) years on or before September 1st in the school year for which they are being registered.

For Kindergarten children pre-registering for the next school year, spring registration will occur at the student’s prospective home school each year. Appointments may be made by contacting your local school’s office. At the conclusion of spring registration, any additional kindergarten students must be registered at the Central Registration office. Students in grades 1-12 will always be registered through the Central Registration office.

The staff at our Central Registration office will be able to schedule appointments, answer your questions and provide information regarding necessary paperwork needed for the registration process. Please contact the office at:

DISTRICT ADMINISTRATION BUILDING/CENTRAL REGISTRATION
3030 C. G. Zinn Road
Thorndale, PA 19372
610-466-2400
www.casschools.org

Please call to make an appointment as walk-ins are not permitted.

Your registration is scheduled for:
DATE: ________________________________
TIME: ________________________________
WITH: ___________________________________
**REGISTRATION CHECKLIST**

<table>
<thead>
<tr>
<th>FOR OFFICE USE ONLY</th>
<th>Time: _______</th>
<th>Initials: _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>To: ____________________________</td>
<td>Entry Code: E1 E2 E3 R3 R4 R5 R6 R7 R8</td>
<td></td>
</tr>
<tr>
<td>Student Name: ________________________</td>
<td>Residency Code: R RA NRF</td>
<td></td>
</tr>
<tr>
<td>CASD ID: ____________________________</td>
<td>Previous District: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Registration Date: ___________ Grade: _______</td>
<td>Previous School: ____________________________</td>
<td></td>
</tr>
<tr>
<td>School Assigned: ____________________________</td>
<td>Transportation Notified: Y N Start Date: ___________</td>
<td></td>
</tr>
<tr>
<td>School Appointment Date: ____________________________</td>
<td>US Enrollment Date: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Birth Certificate #: ____________________________</td>
<td>PA Enrollment Date: ____________________________</td>
<td></td>
</tr>
<tr>
<td>IEP Noted: Y N SE Depart. Date Notified: ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Parent Use Only**

- [ ] Bring Registration Form
- [ ] Bring Proof of Age
- [ ] Bring Immunization Records
- [ ] Bring Proof of Residency
- [ ] Bring Recent Report Card/Transcript
- [ ] Bring Special Education Files (if applicable)
- [ ] Home Language Survey
- [ ] Parental Registration Statement
- [ ] Authorization for Release of Records
- [ ] Authorization for Immunization Release
- [ ] Medical Emergency/Health History

**Office Use Only**

- [ ] Registration Form
- [ ] Proof of Age
- [ ] Immunization Records
- [ ] Proof of Residency
- [ ] Recent Report Card/Transcript
- [ ] Special Education Files (if applicable)
- [ ] Home Language Survey
- [ ] Parental Registration Statement
- [ ] Authorization for Release of Records
- [ ] Authorization for Immunization Release
- [ ] Medical Emergency/Health History

**Documents eMailed/Faxed to School:**

Parents:

________________________

________________________
PA STATE REQUIRED DOCUMENTS FOR ALL CHILDREN

All applications for registration of students must contain the following:

1. Proof of Age [24 P.S. §13-1304; Policy 201]
   - Original or certified birth certificate or;
   - Passport or;
   - Original or certified baptismal certificate, if date of birth is indicated.

2. Immunization Records [24 P.S. §13-1303a; Policy 201]
   - Certificate of immunization.

   Students who are not immunized as required by the Pennsylvania Department of Health, or who are not medically or religiously exempt may not be admitted to school.

3. Proof of Residency* [24 P.S. §13-1302; Policy 202]
   Application for registration must be accompanied by one (1) proof of residency from List ‘A’ and two (2) proofs of residency from List ‘B’.

   List A (one (1) of the following)
   1. Fully executed current residential lease and/or;
   2. Recorded deed and/or;
   3. Mortgage settlement document(s) or mortgage payment book.

   AND

   List B (two (2) of the following)
   1. Valid Pennsylvania driver’s license with current address and/or;
   2. Valid vehicle owner’s card with current address and/or;
   3. Utility bill (provided within 30 days if newly moved) and/or;
   4. Valid Pennsylvania identification card and/or
   5. Check stub from wages, public assistance or social security issued within the past 30 days and/or
   6. Letter from employer verifying address on employment records.

   If you reside with another family in the Coatesville Area School District, please complete a Multiple Occupancy Form which must be notarized.

4. Parent Registration Statement [24 P.S. §13-1304a; Policy 218.1]
   1. Parent Registration Statement attesting to whether the student has been or suspended or expelled for offenses involving drugs or alcohol, weapons or violence.

   The above mandated documents shall be completed and filed with the school district prior to any child being accepted as a pupil.
School Children Immunizations

Pennsylvania School Immunization Requirements

Authority: 28 Pa. Code § 23(C)

**All Students** need the following immunizations to attend school:

- 4 doses of tetanus* (1 dose on or after the 4th birthday)
- 4 doses of diphtheria* (1 dose on or after the 4th birthday)
- 3 doses of polio
- 2 doses of measles**
- 2 doses of mumps**
- 1 dose of rubella (German measles)**
- 3 doses of hepatitis B
- 2 dose of varicella (chickenpox) with first dose on or after 1st birthday or history of disease

*Usually given as DTP or DTaP or DT or TD

** Usually given as MMR with first dose on or after 1st birthday

**Students in 7th Grade also need the following immunizations:**

- 1 dose of tetanus, diphtheria, acellular pertussis (Tdap) if 5 years has elapsed since last tetanus immunization

- 1 dose of meningoccal conjugate vaccine (MCV)

Proof of immunization means a written record showing the dates (month, day, year) your child was immunized.

The only exceptions to the school laws for immunization are medical reasons and religious beliefs. If your child is exempt from immunizations, your child may be removed from school during a disease outbreak.
COATESVILLE AREA SCHOOL DISTRICT  
Central Registration Office  
3030 C. G. Zinn Road, Thorndale, PA 19372  

STUDENT REGISTRATION FORM  

For Office Use Only  
Student #  
PA State ID#:  
Registration Date:  
Entry Code:  
District Enrollment Date:  
State Enrollment Date:  
US Enrollment Date:  

START HERE -- PLEASE PRINT  

Student's Legal Name  
(First)  
(Middle)  
(Last)  

Home Address:  
(Hintex Number)  
(Street or Road Name)  
(Apartment or Unit Number)  
City:  
State:  
PA Zip:  
Home Phone:  
Unlisted?  
Mailing address: (if different from above):  

City:  
State:  
PA Zip:  

Birth Date _____/_____/_____

Gender:  
□ M  
□ F  
Student is: (check one)  
□ US Citizen  
□ Immigrant  
□ Migrant  

Grade: (Circle one)  
K  
01  
02  
03  
04  
05  
06  
07  
08  
09  
10  
11  
12  
Other:  

Ethnicity: (check one)  
□ Hispanic/Latino  
□ Yes  
□ No  

Race: (check one or more)  
□ White  
□ Black/African American  
□ Asian  
□ Am Indian/Alaskan Native  
□ Native Hawaiian/Pacific Islander  

Student Resides at the Address Above with:  
□ Both Parents  
□ Father Only  
□ Mother Only  
□ Step Father  
□ Step Mother  
□ Guardian (relationship to student)  
□ Grandmother  
□ Grandfather  
□ Aunt  
□ Uncle  
□ Sister  
□ Brother  
□ Foster Parent  

Father (Mr. Dr.)  
(Write if applicable)  
□ Jr.  
□ Sr.  
□ II  
□ III  
□ IV  

Or Guardian (Dr. Mr.)  

Home Phone:  
Cell Phone:  
Employer:  
Work Phone:  
Address: (only if different from student)  
City:  
State:  
Zip:  
Address above to also receive district mailings  
□ Yes  
□ No  
E-Mail address:  

Mother (Ms. Mrs. Dr.)  

Or Guardian (Ms. Mrs. Dr.)  

Home Phone:  
Cell Phone:  
Employer:  
Work Phone:  
Address: (only if different from student)  
City:  
State:  
Zip:  
Address above to also receive district mailings  
□ Yes  
□ No  
E-Mail address:  

Type of Residency: (Check one)  
□ Resident  
□ Foster Child  
□ Guardianship  
□ Future Resident  
□ Non-Resident  

□ Multi-Occupancy Resident  
□ Foreign Exchange  
Homeless:  
□ Yes  
□ No  
Residing in shelter:  
□ Yes  
□ No  
Placing Agency Name:  
Phone #:  
Contact:  

Does the student have any health related problems that require attention?  
□ Yes  
□ No  

If yes, what is the nature of the problem?  

Has the student been identified for any of the following services?  
□ Special Ed  
□ ESL  
□ Gifted  
□ 504  
□ Other  

Language Spoken in the Home:  

Country of Origin:  

Please continue to Side 2  

Rev06/30/15
### Emergency Contact Information:
(Please list others who can be contacted by the school during the day)

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Contact Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship:</td>
<td>Relationship:</td>
</tr>
<tr>
<td>Home Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>Cell Phone:</td>
</tr>
<tr>
<td>Work Phone:</td>
<td>Work Phone:</td>
</tr>
</tbody>
</table>

Birth Certificate #: __________ Birth City/State: __________________________ Birth Country: __________

### Former School Information:
Former School District: __________________________

Last School Attended: __________________________

Address: __________________________

City: __________ State: __________ Zip: __________ Phone: __________

Last Grade: _______ Last Date Attended: __________

### Please List Any Brothers or Sisters Residing at the Same Address:

<table>
<thead>
<tr>
<th>Name (Last Name, First Name)</th>
<th>Date of Birth</th>
<th>Gender (Circle one)</th>
<th>Grade</th>
<th>School Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male or Female</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

__Signature of Parent/Guardian__

__Date__

The Coatesville Area School District shall provide equal opportunities for education to all persons regardless of their race, religion, color, ancestry, national origin, sex, handicap or disability as provided by the Pennsylvania Fair Educational Opportunities Act, 24 P.S. §5502 et seq., the Pennsylvania Human Relations Act, 42. For information regarding civil rights, grievance procedures, or services, activities and facilities that are accessible to and usable by handicapped persons, contact the Director of Pupil Services, 3030 C. G. Zinn Road, Thorndale, PA 19372. Phone: 610 466-2600.

__Data Entry Date:__________________ Entered By:__________________

Send copy of Registration Form to: Home School, Transportation and Special Education (when applicable)
HOME LANGUAGE SURVEY

The Office of Civil Rights (OCR) requires that all Local Education Agencies (LEA's) identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the initial step in the identification process.

School District: ___________________________ Date: ____________
School: ___________________________________
Student's Name: __________________________ Grade: ____________

1. What is/was the student's first language? ______________________

2. Does the student speak a language(s) other than English? ☐ Yes ☐ No
(Do not include languages learned in school.)
If yes, specify the language(s): ______________________________

3. What language(s) is/are spoken in your home? _________________

4. Has the student attended any United States school in any 3 years during his/her lifetime? ☐ Yes ☐ No
If yes, complete the following:
Name of School ____________________________ State ____________ Dates Attended
________________________________________
________________________________________
________________________________________

Person completing this form: ____________________________
(If other than parent/guardian)
Parent/Guardian signature: ____________________________

---

1 The local education agency (LEA) has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the LEA has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the LEA may conduct screenings or ask for related information about students who are already enrolled in the school as well as from students who enroll in the LEA in the future.

Revised July 2013
“Excellence in Education”

PARENTAL REGISTRATION STATEMENT

Student Name: ____________________________________________  
Date of Birth: ____________________ Grade: ____________________  
Parent or Guardian Name: ____________________________________  
Address: __________________________________________________

Telephone Number - Home: ____________________ Work: ____________________

The SAFE SCHOOLS section of the Pennsylvania School Code §13-1304-a states in part “Prior to admission to any school entity, the parent, guardian or other person having control or charge of a student shall, upon registration, provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act of offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property.”

Please complete the following:  

AFFIRMATION

I, the undersigned, do hereby swear or affirm that my child was ______ was not ______ previously suspended or expelled, or is ______ is not ______ presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, alcohol or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. §13-1304-A(b) and 18 Pa. C.S.A. §4904, relating to unsworn falsification to authorities, and the facts contained herein are true and correct to the best of my knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled: ____________________

Dates of suspension or expulsion: ____________________  
(Please provide additional schools and dates of expulsion or suspension on back of this sheet.)

Reason for suspension/expulsion (optional) ____________________

_____________________________ ____________________
Signature of Parent or Guardian Date

Any willful false statement made above shall be a misdemeanor of the third degree.  This form shall be maintained as part of the student's disciplinary record.

AN EQUAL OPPORTUNITY EMPLOYER
Coatesville Area School District
Release/Exchange of Information Form

Student Name (Last, First)                        Date of Birth                        Grade

In order to provide and receive information with another person/organization regarding the student named above, Coatesville Area School District requires the permission of the student’s parent/guardian.

By signing this form, you are giving permission for information about your child to be exchanged between Coatesville Area School District and the person/organization listed below:

Person(s)/ Organization: ________________________________
Phone: __________________ Fax: __________________

Types of information to be released from the person/organization listed above to Coatesville Area School District:

☐ Educational Records (Grades, attendance, etc.)  ☐ Psychological Report(s)
☐ Medical/Neurological Information                   ☐ Speech/Hearing Information
☐ Psychiatric Information/Report(s)                 ☐ IEP/Special Education Reports/Records
☐ Summary of Services Received                      ☐ Treatment Summary or Treatment Updates
☐ Other (specify): ________________________________

I certify that I am the parent, legal guardian, or appointed educational surrogate of the student named above. I hereby give permission for the exchange of information as requested. I am aware of my legal rights regarding the release of personally identifiable information, including my right to withdraw permission at any time and to get copies of the information released upon written request. I understand that this permission is valid only for the purpose stated above.

Parent/Guardian’s Signature: __________________________ Date: __________________

Student’s Signature: __________________________ Date: __________________

This consent is valid from __________________ to __________________ (maximum 1 year)

Office Use Only:
PLEASE FORWARD RECORDS TO:

Attach address
label here
COATESVILLE AREA SCHOOL DISTRICT
Administration Building
3030 C. G. Zinn Road, Thorndale, PA 19372

AUTHORIZATION TO RELEASE IMMUNIZATION RECORDS

Release of confidential information regarding:

Student Name: ___________________________ Date of Birth: ___________ Grade: ___________

Name of Last School Attended: ____________________________________________________________

Last School's Phone: ______________________ Last School's Fax: ____________________________

Last School's Complete Mailing Address: __________________________________________________

____________________________________________________

Please fax this form and Immunization records to:

COATESVILLE AREA SCHOOL DISTRICT
Attn: Central Registration
Fax: 610-383-4064 1-610-672-9940

Should there be any questions, please contact Central Registration at 610-466-2400

I understand that I have the right to review those records before they are disclosed or used. I understand that I may revoke this consent, in writing, at any time except, to extent action has been taken. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this form in order to receive treatment. This information has been disclosed to the above person, organization, or agency from records whose confidentiality is protected by Pennsylvania Law and/or Federal Public Law 93-242 and is in compliance with person, organization, or agency from making any further disclosure of this information with prior written consent. I understand that any disclosure of this information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

______________________________
Parent/Guardian Signature

______________________________
Date

This consent is valid from ________________ to ________________ (maximum 1 year)

______________________________
Signature of School Official

______________________________
Date

Note: Pursuant to the provisions of the Family Educational Rights and Privacy Act 20 USC 1232g(b)(1)(A), parental permission is not required to release or transfer student records to officials of other schools or school systems in which the student seeks or intends to enroll, upon the condition that the student's parents be notified of the transfer, receive a copy of the record if desired, and have an opportunity for a hearing to challenge the content of the record.

Policy 203
STUDENT NAME ________________________________

DATE OF BIRTH ______________________________

DATE FORM COMPLETED ________________________

INFORMATION FOR MEDICAL EMERGENCIES

PARENT/GUARDIAN:

Mother Name __________________________________

Home Address __________________________________

Home Phone Number ______________________________

Work Place ______________________________________

Work Phone Number ______________________________

Father Name ____________________________________

Home Address __________________________________

Home Phone Number ______________________________

Work Place ______________________________________

Work Phone Number ______________________________

Grandparent (or other relative name) ________________

Home Address __________________________________

Home Phone Number ______________________________

Work Place ______________________________________

Work Phone Number ______________________________

PERSON LOOKING AFTER CHILD AFTER SCHOOL:

Name _________________________________________

Address _________________________________________

Phone Number __________________________________

DOCTOR

Name _________________________________________

Phone Number ________________________________

DENTIST

Name _________________________________________

Phone Number ________________________________
SPECIAL HEALTH NEEDS (Circle Yes or No)

Has the pupil ever had any serious illness or operation? ............................................ YES   NO
What? ___________________________ When? ___________________________

Is the pupil going to a hospital, clinic or doctor now for treatment of a condition? ........... YES   NO
What for? ___________________________ When? ___________________________

Apart from vitamins, is the pupil taking any medication at this time? ................................ YES   NO
Name of Medication ___________________________ When? ___________________________
What time during school hours? ________________________________________________
What for? ___________________________________________________________________

Is the pupil allergic to anything, such as foods, plants, insects, medication? .................. YES   NO
What? _______________________________________________________________________

Has the pupil ever had any convulsions? ................................................................. YES   NO
When? ___________________________ How frequently? ___________________________
Treatment _____________________________________________________________________

Does the pupil need a special diet or have any food problems? .................................. YES   NO
Give details ___________________________________________________________________

Does the pupil have any special health needs, restrictions or activities or problems
the school should know? .......................................................................................... YES   NO

Has the pupil had any other illnesses, accidents, broken bones? ................................. YES   NO
When? ___________________________ What was the problem? _______________________

Has the pupil ever been seen by a dentist? ................................................................. YES   NO
When? ___________________________ Name of Dentist _____________________________

Signature of Mother/Guardian _____________________________________________________

Date __________________________________________________________________________

Signature of Father/Guardian ______________________________________________________

Date __________________________________________________________________________
STUDENT NAME: ____________________________________________

STUDENT HEALTH HISTORY (ENTRY)

A. Pre-Natal History (circle Yes or No)

1. Did the mother have any major illness during pregnancy? Yes No
2. Did the mother take any medication or drugs (other than iron or vitamins during pregnancy? Yes No
3. Did the baby come on time? Yes No

B. Developmental History

1. What was the baby's weight? ____________________________
2. Did the baby have any trouble while in the hospital? Yes No
3. Did the baby have any special problems in the first six months? Yes No
4. At what age did the child sit alone without support? ________
5. At what age did the child walk alone without support? ________
6. At what age did the child begin to say two or three words together? ________
7. Can the child use the toilet without help? Yes No
8. If the child wet the bed, at what age did they stop? ________

C. Family Health History

1. Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had: Allergy: food/medication/environment, asthma, cancer, drug or alcohol addiction, diabetes, heart disease, nervous breakdown, seizures, tuberculosis, lead poisoning, sickle cell, vision/hearing/learning problems, anemia, other inherited or family diseases.

2. Family Members (note any special relationship such as step-parent, adopted, foster child)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Age</th>
<th>Name</th>
<th>State of Health</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Have any family members died? (not including miscarriages) Yes No

4. How many people live in the same house as the child? ________

5. Are there any family problems such as housing, employment, food, etc. Yes No
D. CHILD'S HEALTH HISTORY

1. Check any of the following illnesses the child has had:

   _______ Read Measles
   _______ German or "3 Day" Measles
   _______ Whooping Cough
   _______ Chicken Pox
   _______ Rheumatic Fever
   _______ Pneumonia

2. Has the child had more than six colds or throat infections, with a fever, a year? .......... Yes  No
3. Has the child had any trouble with ears or hearing? .......... Yes  No
4. Has the child had any trouble with eyes or seeing? .......... Yes  No
5. Has the child had any trouble with teeth? .......... Yes  No
6. Has the child ever had a convulsion (fit or seizure)? .......... Yes  No
7. Has the child ever had a fainting spell? .......... Yes  No
8. Does the child complain of headaches? .......... Yes  No
9. Has a doctor ever said the child had a heart murmur? .......... Yes  No
10. Does the child have trouble keeping up with other children? .......... Yes  No
11. Do any foods disagree with the child? .......... Yes  No
12. Does the child often have diarrhea? .......... Yes  No
13. Has constipation ever been much of a problem for this child? .......... Yes  No
14. Has the child ever had worms or parasites? .......... Yes  No
15. Have you ever seen blood in the child's stools (bowel movements)? .......... Yes  No
16. Has the child ever had yellow jaundice or trouble with the liver? .......... Yes  No
17. Does the child complain of belly aches? .......... Yes  No
18. Does the child have any problems with urination? .......... Yes  No
19. Does the child have any skin problems? .......... Yes  No
20. Has the child ever had eczema or allergy? .......... Yes  No
21. Has the child ever had asthma or wheezing? .......... Yes  No
22. Has the child ever had an allergy or reaction to any medication or injections? .......... Yes  No

   What medication or injection?

23. Does the child seem to have trouble breathing through the nose? .......... Yes  No
24. Does the child snore at night? .......... Yes  No
25. Has the child ever complained of pain in the arms or legs? .......... Yes  No
26. Has the child ever had swelling of any joints or limping? .......... Yes  No
27. Has there ever been any trouble with the child's blood? .......... Yes  No
28. Has the child ever eaten paint or plaster or anything else which is not food? .......... Yes  No
29. Has the child ever been treated for lead poisoning? .......... Yes  No
30. Does the child have any trouble sleeping? .......... Yes  No
31. How does the child go to sleep at night? .......... Yes  No

32. Has the child ever had a skin test to TSS? .......... Yes  No

   Where the results normal?

33. What does the child usually eat for:

   Breakfast: 
   Lunch: 
   Dinner: 
   Snacks: 

Health History obtained from: 

   Signature of Parent/Guardian: 
   Date: 