Date: ____________________

Student's Last Name | First | Middle | Date of Birth | Family Doctor

Father | Mother | (Guardian) | Home Address | Home Phone

Place of Employment (Father) | Phone | Place of Employment (Mother) | Phone | Emergency Phone (If unable to locate parents)

Date Entered School (1) (2) (3) (4) (5)

Siblings: ____________________

List Other Children and Dates of Birth

PAST HEALTH HISTORY

Check below the illnesses your child has had:

Chicken Pox________________ Asthma____________________

Convulsions________________ Allergies___________________

Recurrent Ear Infections ____________Physical Handicap __________

Trouble with bladder or bowel control_________Hospitalizations_______

Present medications____

Other health or behavior problems________________________________

Please explain fully on the back of this form.

FAMILY HISTORY

Cancer____________________ Diabetes________________________

Epilepsy___________________ Heart Disease____________________

IMMUNIZATION RECORD

		1ST	2ND	3RD	4TH	5TH
DPT, DTaP, or DT						
Polio	OPV					
	IPV					
HIB						
Hepatitis B						

MMR #1______ MMR #2______ Varicella______ T.B. Test______

PHYSICIAN'S EXAMINATION

Date________________ Wt.__________ Ht.__________ B.P._________

Visual Acuity R.____________ L.___________ Urinalysis___________

Check appropriate statements below:

____ This child has no apparent physical defects, health problems or behavior disorders.

____ This child has the following physical defects (specify below).

____ This child has the following health problems (specify below).

____ This child has the following behavior disorders (specify below).

List below the specific abnormalities in the areas noted above:

____

____

____

Signature of Doctor

EXAMINING DENTIST REPORT

Check appropriate space. Date________________

1. Does the child have dental problems? _______ yes _______ no

2. If so, have arrangements been made to correct them? _______ yes _______ no

____

Signature of Dentist