

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**

		1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>	5 <sup>TH</sup>
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