Elizabethtown Christian Academy

Student Medical History

Student's Name________________________________ Birth Date_______________ Sex___________

Father's Health_____________________If deceased, cause of death____________________________

Mother's Health_____________________If deceased, cause of death ___________________________

PAST DISEASES— Please list the age at which your child developed any of the following:

Mumps____________Diptheria____________Scarlet Fever_______________Measles_____________

Polio______________Convulsions_________Whooping cough_____________Asthma____________

Pneumonia_________Heart Disease________Ear Discharge______________ Diabetes____________

Hay Fever__________Chicken Pox_________Rheumatic Fever_____________

RECENT DISABILITIES—Please check any that have been noted in your child recently:

Frequent Colds_______Fainting Spells__________Hearing Problems_________Poor Vision_________

Abdominal Pains______Frequent Urination_______Shortness of Breath_______Leg Pains__________

Nose Bleeding________Persistent Cough________Speech Problems_________Dizziness_________

Frequent Sties________Frequent Sore Throat_____Tires Easily______________Allergies__________

Ringworm___________ Dental Defects__________Crippling Conditions________Hernia____________

Does your child have a disability due to illness or accident? If yes, please explain.________________

____

Has your child had a skin test for tuberculosis?____

Has your child been associated with a tubercular patient? If so, when?__________________________

PERSONAL RECORD—Please answer all of the following: Is/does the child:

Overactive?_________Bite fingernails?________Play well with others?________Suck thumb?_______

Eat breakfast?_______Have many fears?______Have temper tantrums?_______Shy?_________

When is the child's regular bedtime?______________________

When is the child's regular rising time?______________________

SIGNATURE OF PARENT:___________________________________DATE:_____________

ELIZABETHTOWN CHRISTIAN ACADEMY

1800 West Broad Street *Elizabethtown, NC 28337* *Phone: 910-862-3427* *www.elizabethtownchristianacademy.org*

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Health Assessment

Child's Full Name ____ DOB______________

Child's Address____

Parents Name____

SECTION 1 (To be completed/signed by a physician):

Date_______________Weight_______________Height_______________Blood Pressure__________________

Vision: Right__________Left__________________Referred to Eye Doctor? Yes______No______

Comments:____

Hearing: Right_________Left__________Hearing Loss Identified? Yes_________No_________

Comments:____

Developmental Screening: Within Normal Range__________________ Needs Follow-up__________________

Illnesses of Developmental Nature (check any of the following that the child has/had):

______Asthma ______Bleeding Problems ______Bone/Muscle Problems ______Urinary/Bladder

______Diabetes ______Bowel Problems ______Cancer/leukemia ______Attention/Learning

______Meningitis ______Stomach Aches ______Convulsions/Seizures ______Heart Problems

______Ear Infections ______Cerebral Palsy ______Emotional/Behavioral ______Vision Problems

______Skin Problems ______Cystic Fibrosis ______Dental Problems ______Speech Problems

______Hearing Problems ______Sickle Cell Anemia ______Other ______None

For those illnesses or developmental problems checked above, please provide additional information on the reverse side of this sheet.

Does the child take medication on a regular basis? Yes________No________

If yes, list the medication, dose, and possible side effects.______________________________________

Does this medication need to be given at school? Yes________No________

If yes, list frequency and duration.____

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IMMUNIZATION RECORD
(to be completed by health care provider)

Enter the date of EACH dose – Month/Day/Year

Vaccine					
DTaP,DTP,DT					
Polio					X
Hib					X
Hepatitis B				X	X
MMR			X	X	X
Measles			X	X	X
Mumps		X	X	X	X
Rubella		X	X	X	X
Varicella		X	X	X	X

State Law Requires the Following Minimum Doses:

5 DTaP, DTP, DT doses (If 4th dose is after 4th birthday, 5th dose is not required, DT requires medical exemption.)

4 Polio Vaccine doses (If 3rd dose if after 4th birthday, 4th dose is not required).

3 Hepatitis B doses (Children born on or after July 1, 1994 are required to have 3 doses).

2 Measles doses (at least 30 days apart; 1st dose on/after 12 months of age).

1 Mumps dose (on/after 12 months of age).

1 Rubella dose (on/after 12 months of age)

1 Varicella dose (Children born on or after April 1, 2001 without documented history of disease).

Exemptions from the North Carolina Immunization Law require that a statement must be on file at school in student's permanent record. Exemption must meet requirements of the law. Consult the local health department.

Medical Exemption ________________________ Religious Exemption ______________________

Signature of Health Care Provider ____________________________ Date ___________________

Address: ____ Phone # _________________

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