Blue Mountain Christian School Health History

To Parents or Guardian: The information requested on this form will be of help to the school authorities in determining the health status of your child and in assisting him to receive maximum benefits from his education opportunities.
Dental exams are required in K or first year of school, 3rd, and 7th grades. Physical exams are required in K or first year of school, 6th, and 11th grades. You are encouraged to have exams by your family dentist and physician.
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Child's full name_____ Sex_____ Phone_____
Address_____ Birthdate_____
Father's Name_____ Address_____
Mother's Name_____ Address_____
Guardian_____ Address_____
Martial Status: Divorced Married Separated____ Live-In____ Single____ Remarried____

Name of Child's Physician or other source of medical care:

_____

Has your child had any of the following? When:? Please check.

Asthma_____ Rheumatic Fever_____ TB Family_____ Allergies_____
Chicken Pox_____ Influenza_____ Epilepsy_____ Convulsions_____
Measles_____ Pneumonia_____ Operations_____ What_____
Mumps_____ Tonsillitis_____ Diabetes_____ Severe Fall_____
German Measles _____ Polio_____ Hospitalized_____ Head Injury_____
Scarlet Fever_____ TB self_____ Heart Defect_____ Accident_____
Eye Disease or injury_____ Emotional problems_____
Cerebral Palsy_____ Speech Difficulties_____ Hearing Loss____Tubes Inserted___
Hand used most frequently—right___ left____ On medication? If so, what_____
Did your child crawl before walking? yes_____ no_____ Age walked____ Age talked_____
Does your child bump into things frequently? yes_____ no ___ Wear glasses? yes_____ no___
Does your child have complete bowel control? yes_____ no ___ Bladder control? yes_____ no___
Did mother have measles or serious illness during pregnancy? yes_____ no_____

Immunizations and Tests or attach list

Measles (Reg.7day) Date_____
Rubella (Ger.3day) Date_____
Mumps Date_____
#2 MMR /Measles Date _____

	1st	2nd	3rd	Boosters		
Diphtheria						
Tetanus						
Pertussis						
Polio Oral						

Booster
Hepatitis B Series #1____ #2_____ #3_____

TB (Tine or x-ray) Date_____ HIB Date_____

Family History—(grandparents, parents, brothers, sisters) Please circle relative and disease if any: TB, diabetes, heart disease, allergies, asthma, epilepsy, blindness, deafness, kidney condition, nervous breakdown

Parent/Guardian Signature_____ Date_____