STUDENT HEALTH FORM

500 New Creation Road, Newark, MO 63458
Phone 660-284-4800

Student's Name: ____________________

Date: ____________________

PERSONAL MEDICAL HISTORY

(Please indicate "yes" or "no" if you have had any of the following; if answered "yes" please explain)

Asthma ____________________

Diabetes____________________

Tuberculosis ____________________

Hearing Loss ____________________

Heart Problems ____________________

Sexually Transmitted Diseases ____________________

Allergies ____________________

Chicken Pox ____________________

Poor Vision ____________________

High Blood Pressure ____________________

Adverse reaction to medications____________________

(List these meds)____________________

List any other health problems that the school should be aware of:

____

IMMUNIZATION RECORD

(State month and year of immunization or attach a copy of your immunization record)

DPT or DT ____________________
(diphtheria, tetanus, pertussis)

TOPV ____________________
(oral polio)

Rubella ____________________
(3-day measles)

Rubella ____________________
(7-day, hard measles)

Mumps ____________________
(please indicate if given in combined vaccine)

Tuberculin skin test date ____________________
(results)____________________

Hepatitus B ____________________

HiB ____________________

Other vaccinations:

____

REQUIREMENT – ALL medications must be declared!

List any medications taken regularly, dosage, times taken per day and reason for taking:

Medication	Dosage	Times per day	Reason for taking

OTHER HEALTH INFORMATION

Any known food or other allergies? ____________________

Family physician name and phone number: ____________________

In case of emergency contact: Name ____________________ Relationship ____________________

Home Phone # ____________________ Work Phone # ____________________

Health Insurance Company Name ____________________ Policy # ____________________

PHYSICIAN'S RELEASE FOR PHYSICAL EDUCATION PROGRAM

I certify that ____________________ is free from communicable disease or conditions that would disqualify him/her to participate in a physical education program of Heartland Christian College.

Limitations are as follows: (if none, write "none") ____________________

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____________________ ____________________

Physician's Signature (required) Date