STUDENT HEALTH HISTORY for Heritage Hall Christian School

6401 W. River Road, Muncie IN 47304
Phone: 765-289-6371

Please complete top portion even if separate immunization or physical exam documents are attached.

Student _____ [] Male [] Female Grade_____
Last name First Name Middle Name

Date of Birth ____/____/_____ Place of Birth_____
City State (Country)

Birth Father:_____ Birth Mother:_____

ALLERGIES (foods, medications, etc): _____

HEALTH PROBLEMS (serious injury or surgery, congenital or ongoing needs that may require special attention):

_____

_____

_____

MEDICATIONS TAKEN REGULARLY:_____

Does the student experience
[ ] frequent colds
[ ] frequent ear infections
[ ] tonsillitis
[ ] asthma
[ ] seizures

If student has had any of the following, indicate approximate year
[ ] chicken pox_____
[ ] Rubella_____
[ ] measles_____
[ ] mumps_____
[ ] whooping cough_____
[ ] scarlet fever_____
[ ] tuberculosis_____

PHYSICAL EXAMINATION: Required for all students in grades **K5, 3, 6, 9 and those enrolling for the first time.** A Sports Physical is required for all student athletes each year of participation. *Physician's form is accepted.*

0-normal X-needs attention 00-corrected

Eyes_____
Ears_____
Nose_____
Tonsils_____
Teeth_____
Skin/Scalp_____
Neck Glands_____
Thyroid_____
Lungs_____
Heart_____
Abdomen_____
Musculo-Skeletal_____

Height_____Weight_____

Blood pressure_____

Heart rate_____

Gen. Nutrition_____

[] Should [] should NOT participate in physical education or athletic activities.

Additional remarks or recommendations may be written on the back of this page.

IMMUNIZATION RECORD

State of Indiana Requirements

	1	2	3	4	5	
DTaP/DPT/DT	_____	_____	_____	_____	_____	
any combination						(PS 4; K/1 5 doses)
OPV/IPV	_____	_____	_____	_____		(PS 3; K/1 4 doses)
MMR	_____	_____				(PS 1; K/1 2 doses)
Hep. B	_____	_____	_____			(K/1 3 doses)
Hep. A	_____	_____				(K 2 doses)
Varicella (Chicken pox) vaccine	_____	_____				(K 1; 1 2 doses)

or
This child had chicken pox on or approximately _____
date

Tdap (Tetanus & Pertussis) _____ (6^{th} 1 dose)

MCV4 _____ _____ (6^{th} 1; 12^{th} 2 doses)

Parent Signature _____

**Physician's form or printout is accepted.*

Date of exam:_____

Printed name of Physician_____ Signature or stamp_____