## STUDENT HEALTH FORM

Child's Name____________________________________________

Sex: _____Male _____Female Age_____________ Date of Birth________________________

Parent/Parents' Name:____________________________________________

Address:____________________________________________

Telephone:____________________________________________

**HISTORY – Please indicate if there is a history of any of the following conditions:**

_____Convulsions _____Chicken Pox _____Ear Infections

_____Hepatitis _____Tuberculosis _____Strep Throat

**IMMUNIZATIONS – Please give dates.**

DPT____________________________________________

Polio_______________________________Polio Booster____________________

Measles____________________________________________

Rubella____________________________________________

Mumps____________________________________________

MMR____________________________________________

DT_______________________________DT Booster____________________

Hep 1____________________Hep 2______________________Hep 3______________________

Varicella Vaccine (required for students entering Kindergarten)

____________________________________________

TB Tine Test____________________________________________

**ALLERGIES – Please give all medication and food allergies. Indicate what reaction occurred when the substance was given.**

____________________________________________

____________________________________________

____________________________________________

**CURRENT MEDICATIONS**

____________________________________________

____________________________________________

____________________________________________

**We Teach**

**Hearts and Minds**

P.O. Box 6670

Chesterfield,

Missouri

63006

(314) 579-9610

www.westcountychrisitanacademy.org