CHILD'S MEDICAL HEALTH REPORT

Child's Name: _____ Date of Birth: _____
Parent's or Guardian's Name:_____
Address:_____ City:_____ Phone:_____

IT IS MANDATORY THAT PUPILS WHO SHOW SYMPTOMS OF COMMUNICABLE DISEASES BE EXCLUDED FROM CLASSES UNTIL RE-ADMISSION IS ACCEPTABLE TO SCHOOL AUTHORITIES. YOUR COOPERATION IS GREATLY APPRECIATED.

RECENT HEALTH PROBLEMS (Please check any one of the following noted recently)

4 or more colds yearly _____	Fainting spells _____	Hearing difficulties _____
Frequent sore throats _____	Abdominal pain _____	Tires easily _____
Poor vision _____	Frequent urination _____	Breath shortness _____
Frequent leg pain _____	Allergies _____	Hernia (Rupture)_____
Dizziness _____	Persistent cough _____	Ringworm_____
Frequent sties_____	Speech difficulties_____	Nose bleeding_____
Dental defects_____	Crippling conditions_____	Growing pains_____

Does your child have a disability due to disease or accident?_____
Has your child had a skin test for tuberculosis? _____ Date_____ Results_____

PERSONAL RECORD (Please check any of the following that apply to your child)

Is he/she shy?_____	Overactive?_____	Bites fingernails?_____
Sucks thumb?_____	Has excessive fears?_____	Has temper tantrums?_____
Inquisitive?_____	Plays well with others?_____	Eats breakfast?_____

Please list anything that we may need to know concerning your child.

_____
_____
_____

_____ _____
Signature Date