Bundy Canyon Christian Church & School

HEALTH HISTORY

STUDENT'S NAME:_____ M___ F___ BIRTH DATE:_____

(Must be completed by Parent/Guardian)

COMMUNICABLE DISEASES:	Y/N	DATE
Measles	_____	_____
Rubella	_____	_____
Mumps	_____	_____
Whooping Cough	_____	_____
Scarlet Fever	_____	_____
Rheumatic Fever	_____	_____
Polio	_____	_____
Meningitis	_____	_____
Encephalitis	_____	_____
Tuberculosis	_____	_____
TB in Family	_____	_____
Infectious Hepatitis	_____	_____
Chickenpox	_____	_____
Other: _____	_____	_____

Please answer Yes or No or comment regarding the following questions:

Exposure to Tuberculosis:_____
Serious Injury or Illness (give dates):_____
Operations (give dates):_____
Subject to Headaches:_____
Does your child wear glasses: If yes, last date of eye examination:_____
List any medications your child is currently taking:_____
_____
Does your child have dental needs:_____

Chronic Problems (Past or Present) Please explain:

Hearing Problems:_____ Speech Problems:_____
Vision Problems:_____ Heart Disorder:_____
Diabetes:_____ Asthma:_____
Kidney Disease:_____ Hay Fever/Allergies:_____
Skin Disorder:_____ Frequent Ear Infections:_____
Convulsions/Seizures:_____ Other:_____

Shot records must be submitted prior to your child's first day.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____