CROSSROADS CHRISTIAN SCHOOL

PO Box 249 ♦ Henderson, NC 27536 ♦ (252) 431-1333 Office ♦ (252) 431-0333 Fax ♦ www.ccscolts.org

Student Medical Form
for School Year: 20__ - 20__

Student: ______________________ Birth Date: ______________
Name of Parent or Guardian: ______________________ Date: ______________
Address: ______________ City: ______________ State: ________ Zip: ________

A. MEDICAL HISTORY (To be completed by the parent)

1. Is your child allergic to anything? _____ Yes _____ No If yes, what? ____________
2. Is your child under a doctor's care? _____ Yes _____ No If yes, what? ____________
3. Any previous hospitalizations or operations? _____ Yes _____ No If yes, what? ____________
4. Is your child on any continuous medication? _____ Yes _____ No If yes, what? ____________
5. Any history of diseases or recurrent illnesses? _____ Yes _____ No If yes, what? ____________
6. Does your child have any physical disabilities? _____ Yes _____ No If yes, what? ____________
7. Does your child have any mental disabilities? _____ Yes _____ No If yes, what? ____________

B. WHERE DOES YOUR CHILD RECEIVE HEALTHCARE?

Name of doctor or clinic: ______________________ Phone number: ______________
Date of last physical exam: ______________________
Name of dentist: ______________________ Phone number: ______________
Date of last dental exam: ______________________

C. PHYSICAL EXAMINATION (To be completed by a licensed physician, a certified nurse practioner, or a public health nurse)

Height ____ % Weight _____ % Head _____ Eyes _____ R _____ L _____ Both Ears _____
Nose ____ Teeth _____ Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____
Ext ____ Skin _____ Neurological System _______ Should activities be limited? _______
Explain: ____
Results of Tuberculin Test, if give: Type ______ Date ______ Normal _____ Abnormal _____
Examiner's Signature/Title ____
Phone ____

D. IMMUNIZATION RECORD (the health official must enter the date immunizations were received in the space below or attach a copy of the immunization record.)

TYPE OF VACCINE	#1	#2	#3	#4	#5
*DPT OR DT (circle one)					
*Polio					
** Hib					
*MMR (combined doses)					
*** Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
*** Hep. B (three doses)					
Other					

***Required by State Law **Required by State Law if born on or after 10-01-91 ***Required by State Law if born on or after 7-01-94**

NOTE: If there are any changes in a student's health history, it is the responsibility of the parent/guardian to notify the school and submit a new "Student Medical Form" as soon as possible.

______________________________ ______________________________
Parent Signature **Date**