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: 2010 - 2011

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**