The Rockbridge Christian Academy

Student Health History

The information requested on this form is necessary for the School Health Record of your child. Please complete, in detail, and return.

NAME _____ Address_____
Last First MI

_____

DATE OF BIRTH_____

PLACE OF BIRTH_____ SOCIAL SECURITY NUMBER_____

Mother's name _____ Father's name_____

Please check the illnesses your child has had from birth to the time of entering school. Include date, if known, and important details.

ILLNESS	DATE	ILLNESS	DATE
Allergy_____		Scarlet Fever_____	
Chicken Pox_____		Poliomyelitis _____	
Rubella _____		Rheumatic Fever _____	
Measles_____		Pneumonia_____	
Mumps _____		Any other_____	
Whooping Cough_____		_____	

Please list any operations, serious illness or other existing physical conditions_____
_____

Check any preventive inoculations (shots) your child has had from birth to the time of entering school.

	Date of 1st Injection	Date of 2nd Injection	Date of 3rd Injection	Date Additional Injection
Diphtheria				
Tetanus				
Whooping Cough				
Polio (Salk)				
Polio (Sabin)				
Measles				
Rubella				
Mumps				
Tuberculosis				
Any Other				

Is your child at child at present under medical treatment? YES_____ NO_____
List any health or behavior problem, which you or your family physician feel should be known to the school authorities
_____
_____

Name of Family Physician_____ Phone_____
Address_____

Signature of Parent or Guardian_____

ATTACH: "School Entrance Physical Examination and Immunization Certification—Commonwealth of Virginia"