

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.

<u>ILLNESS</u>	<u>DATE</u>	<u>ILLNESS</u>	<u>DATE</u>
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 1 st Injection	Date of 2 nd Injection	Date of 3 rd 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"