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: 2018 - 2019

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. KNOWN CONDITIONS (Check all that apply.)

Condition	Yes	Comments
Allergies (food, insects, drugs, latex) Epipen? ❑ Yes ❑ No		
Allergies (seasonal)		
Asthma Inhaler? ❑ Yes ❑ No		
Attention Deficit/Hyperactive Disorder		
Behavioral problems		
Developmental problems		
Bladder problem		
Bleeding problem		
Bowel problem		
Cerebral Palsy		
Cystic Fibrosis		
Dental problems		
Depression/Anxiety/Other mental health issues		
Diabetes		

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Student Medical Form
(continued)

Condition	Yes	Comments
Fractured bones		
Head or spinal injury		
Hearing problems or deafness		
Heart problems		
Hospitalizations		
Lead poisoning		
Muscle problems		
Seizures		
Sickle Cell Disease (not trait)		
Speech problems		
Surgery		
Vision problems		

D. 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 _____

E. 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**