HEALTH FORM—MEDICAL RECORD

Waukesha Christian Academy

*Please fill out and return this form and the immunization form so that your registration can be completed.

Student Name:			
	Last Name	First Name	Middle Name
Parent/Guardian Name:			
Address:			
	Street	City	Zip Code

Phone:	( )	**Sex:**		**Birth Date:**	

Disease Record:

Condition	*Yes or No*	*Year*		*Condition*	*Yes or No*	*Year*
Chicken Pox				Mumps		
Rheumatic Fever				Scarlet Fever		
German Measles				Red Measles		

Does the student currently have any allergies? Please list.

Does the student currently have diabetes?

Does the student currently have asthma?

Physician's Medical Examination Record:

Height:		Hearing:	
Weight:		Mouth:	
Blood Pressure:		Teeth and Gums:	
Eyes:		Throat:	
Vision:		Chest:	
Ears:		Extremities:	
Nose:		Speech Defect:	

Are there any health conditions that the school should be aware of?

Restrictions and/or recommendations?

Date Examined: ________________________ Physician's Name: ________________________________