

**New Castle Christian Academy
Medical History Registration
2008-2009**

Student name _____ Date of birth _____ Sex _____

Place of birth _____ Birth certificate number _____
Social security number _____

Father's name _____ Birthplace _____

Step-father's name _____ Birthplace _____

Living yes no
Separated yes no
Remarried yes no
Divorced yes no

Mother's name _____ Birthplace _____

Step-mother's name _____ Birthplace _____

Living yes no
Separated yes no
Remarried yes no
Divorced yes no

Person(s) with whom child lives _____ relationship _____

Residence _____ phone number _____

Father employed by _____ mother employed by _____

Number of older brothers _____ number of older sisters _____

Number of younger brothers _____ number of younger sisters _____

Entered from school/Kindergarten _____

Location _____

Lefthandedness yes no

Additional information or health problems _____

(over)

Grade _____

I. History

- Allergies
- Kidney trouble
- Convulsions or seizures
- Rheumatic fever or heart problem
- Diabetes
- Exposure to tuberculosis
- Emotional problems
- Accidents
- Pneumonia or bronchitis
- Operations (tonsils, etc.)
- Contagious diseases:
 - Fifth disease
 - Chicken pox
 - Scarlet fever
 - Other

II. Medications child is taking _____

III. Child presently under medical care? Yes no

IV. Child taking daily medication? Yes no

V. Immunization (give dates)

DPT series _____ Boosters _____
Polio (OPU) _____
MMR _____
HIB _____
TB test _____
Hepatitis B _____

Pennsylvania state law REQUIRES that a child entering school for the first time have a physical and dental examination.

1. Consent for physical examination:

- I request that the physical exam be conducted by the school physician.
- I will have the exam done by my family physician and report to you on the form provided by the school.

2. Consent for dental services program:

- I grant permission for my child to receive a dental screening at school.
- I will have the dental screening done by my family dentist and the information forwarded to the school.

3. Consent for tuberculin tine test:

- I grant permission for my child to receive this tuberculin screening test.
- I will have this test done by my family physician and the results forwarded to the school.

IF THE COMPLETED FORMS FROM YOUR FAMILY PHYSICIAN AND DENTIST ARE NOT RETURNED TO THE ACADEMY BY THE LAST WEEK OF SEPTEMBER, YOUR CHILD WILL BE GIVEN THESE TESTS IN SCHOOL.

Date _____ Parent/guardian signature _____