



STUDENT HEALTH RECORD
Wilmington Christian Academy
PO Box 801
Wilmington, OH 45177
937-383-1319

Name _____ Date _____

Address _____

City _____ Zip Code _____

Parent(s)/Guardian _____ Phone # _____

Student Birth date _____ Grade _____ Sex _____

.....

Date of Last Dental Exam _____

Dentist Name _____

Dentist Address _____

.....

REQUIRED IMMUNIZATIONS KINDERGARTEN THROUGH 12TH GRADE

Note to parents: Wilmington Christian Academy also requests a copy of the immunization record on either the physician's office form or the county health department form to accompany this health record. Day, month, and year of each dose is required.

DTaP/DTP/DT/Td (1) _____ (2) _____ (3) _____ (4) _____ (5)* _____
 (Diphtheria, Tetanus, Pertussis)

POLIO (1) _____ (2) _____ (3) _____ (4)** _____

MMR (1) _____ (2) _____
 (Measles, Mumps, Rubella)

HEP B (1) _____ (2) _____ (3) _____
 (Hepatitis B)

Varicella (Chicken pox) (1) _____

Other: _____

*Students receiving all four primary immunization doses of DTP or DTaP prior to their 4th birthday MUST receive a single booster dose prior to kindergarten entry.

**Students receiving a third dose of Polio Vaccine (either DPV or IPV) prior to the 4th birthday MUST receive a fourth dose prior to kindergarten entry.

Please indicate your child's past/present disease(s):

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Epilepsy, Seizures	<input type="checkbox"/> Frequent Skin Infections	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> German Measles	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Mumps
<input type="checkbox"/> Eczema	<input type="checkbox"/> Old Fashion Measles	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Asthma or Wheezing	<input type="checkbox"/> Other	<input type="checkbox"/> Stool Soiling

Is your child on any medication? Yes No Please indicate the medication and reason it is being taken:

Are there medications given "as needed" Yes No Please indicate reason medication is being taken:

Does student have a physical handicap? Yes No
Explain:

Has student ever had a convulsion? Yes No
Explain:

Describe student's eating habits:

Does student have trouble with bladder control? Yes No

Is student a bed-wetter? Yes No

Poor Vision? Yes No

Chronic diarrhea or constipation? Yes No

Poor Hearing? Yes No

Would you say student is very active, average, quiet

Please state any health problems you wish the school to know:

Nervous twitching or tics? Yes No

Physical Activity: Limitations? Yes No
(If child has limitations, please send a note from your physician to the school.)

Page 3 is for Kindergarten Students ONLY!

KINDERGARTEN – REQUIRED PHYSICAL EXAM

Kindergarten Physical Exam Date _____ Physician's or CNP Signature _____

Physician's Address _____

Allergies _____

RECOMMENDED ITEMS FOR SCHOOL PHYSICALS

Did examination reveal any abnormalities in the following areas?

	YES	NO		YES	NO		YES	NO
General Appearance			Neuro Muscular			Skeletal System		
Abdomen			Skin			Lymph Nodes		
Eyes			Ears			Noses/Throat		
Lungs			Genitalia			Teeth/Gums		
Tongue and Palate			Heart BP:			Emotional		

Weight:

Height:

Head (Inches):

DESCRIBE FULLY ANY ABNORMALITIES:

HCT>34% is acceptable for 3--4 YR

HCT>36% is acceptable for 4--5 YR

HGB> is acceptable for all ages

F.E.P., if HCT or HGB fall below amount indicated.

Lead Test if R.E.P. is High:

Sickle Cell Anemia:

Urinalysis:

Hearing:

Speech:

Vision: