HEALTH RECORD QUESTIONNAIRE

Heritage Christian School, Findlay, OH

Student ______________________________ DOB ______________ M / F

Father's Name ______________________ Mother's Name ______________________

Health Record (You may submit a copy of your child's immunization record instead of completing the record below or we can make a copy in the school office.)

If you choose for your child NOT to receive immunizations, please submit a written note.

TYPE	DATE (MONTH / DAY / YEAR)				
DPT/DT or DtaP					
DT/Td					
Polio					
MMR					
Hepatitis B					
Varicella					
HIB (prior to age 5 only)					
Tetanus					
Tuberculin Test (Date/Result)					
OTHER					

This section must be completed for ALL students.

	Yes	No
Frequent Headaches	______	______
Frequent Sore Throats	______	______
Frequent Dizziness	______	______
Growing Pains	______	______
Frequent Nosebleeds	______	______

	Yes	No	
Hearing Defect	______	______	
Speech Defect	______	______	
Sight Defect	______	______	(glasses / contacts)
Heart Defect	______	______	

Other ____

ALLERGIES (explain) ____

If your child is under any medication, please explain. ______________________________

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IS THERE ANY PHYSICAL PROBLEM WHICH THE SCHOOL SHOULD KNOW ABOUT IN ORDER TO WORK MORE EFFECTIVELY WITH YOUR CHILD?

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Signature & Date ____