# CALVARY BAPTIST ACADEMY
# MEDICAL HISTORY FORM

**IT IS MANDITORY** that students who show symptoms of communicable disease be excluded from classes, until readmission is acceptable to school authorities. Your cooperation will be greatly appreciated. Thank you!

Student's Name_____ Birth_____ Male_____ Female_____

**PAST DISEASE –** (Please check yes or no to all of the following and list their age at the time of the illness!)

| | Yes | No | Age | | Yes | No | Age |
|---|---|---|---|---|---|---|---|
| Asthma | ___ | ___ | ___ | Measles | ___ | ___ | ___ |
| Cancer | ___ | ___ | ___ | Mumps | ___ | ___ | ___ |
| Chicken Pox | ___ | ___ | ___ | Pneumonia | ___ | ___ | ___ |
| Convulsions | ___ | ___ | ___ | Polio | ___ | ___ | ___ |
| Diabetes | ___ | ___ | ___ | Rheumatic | ___ | ___ | ___ |
| Diphtheria | ___ | ___ | ___ | Scarlet Fever | ___ | ___ | ___ |
| Discharged Ears | ___ | ___ | ___ | Syphilis | ___ | ___ | ___ |
| Gonorrhea | ___ | ___ | ___ | *Tuberculosis | ___ | ___ | ___ |
| Hay Fever | ___ | ___ | ___ | Whooping Cough | ___ | ___ | ___ |
| Heart Disease | ___ | ___ | ___ | | | | |

Other_____

*Has your child had a skin test for tuberculosis? No___ Yes___ Date Administered_____
*Has your child been associated with a tubercular patient? No___ Yes___ Yes___ When? _____

**RECENT HEALTH PROBLEMS –** (Please check any one of the following noted recently!)

| | | | | | |
|---|---|---|---|---|---|
| Abdominal Pains | _____ | Frequent Leg Pains | _____ | Nose Bleed | _____ |
| Aids | _____ | Frequent Sore Throats | _____ | Persistent Cough | _____ |
| Allergies | _____ | Frequent Sties | _____ | Poor Vision | _____ |
| Crippling Conditions | _____ | Frequent Urination | _____ | Ringworm | _____ |
| Dental Problems | _____ | Growing Pains | _____ | Shortness of Breath | _____ |
| Dizziness | _____ | Hearing Difficulty | _____ | Speech Difficulty | _____ |
| Fainting Spells | _____ | Hernia (rupture) | _____ | Tires Easily | _____ |
| 4 or More Colds Yearly | _____ | HIV Positive | _____ | | |

**Other**_____

Does your child have a disability due to a disease or an accident? No___ Yes___ If so, what?_____

**PERSONAL RECORD** – (Please check yes or no to all of the following!)

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bites fingernails? | ___ | ___ | Plays well with others? | ___ | ___ |
| Eats breakfast regularly? | ___ | ___ | Shy? | ___ | ___ |
| Excessive fears? | ___ | ___ | Sucks thumb? | ___ | ___ |
| Inquisitive? | ___ | ___ | Temper tantrums? | ___ | ___ |
| Overactive? | ___ | ___ | Tires easily? | ___ | ___ |

**Does your child take any medicine on a regular basis? No___ Yes___ If so, what?**_____
_____

**Is there any medical information not listed about your child, which you feel we need to be informed? No___ Yes___ If so, what?**_____

**Home Phone** _____
**Dad's Work Phone** _____
**Dad's Cell #** _____
**Mom's Work Phone** _____
**Mom's Cell #** _____

*(Date)* _____ *(Signature of Parent)*_____