IMMANUEL CHRISTIAN SCHOOL

MEDICAL HISTORY

Pupil's Name	Birth Date	Sex
Father's Occupation	Mother's Occupation	
Father's Health	If deceased, cause	
Mother's Health	If deceased, cause	
PAST DISEASES – If your child has had any of the following, state age when he/she had them.		
Mumps	Diphtheria	Polio
Measles	Scarlet Fever	Convulsions
Whooping Cough	Rheumatic Fever	Heart Disease
Asthma	Chicken Pox	Diabetes
Hay Fever	Pneumonia	Discharging Ears
Syphilis	Gonorrhea	
RECENT DISABILITIES – Please check any one of the following noted recently.		
4 or more colds yearly	Fainting spells	Hearing difficulty
Frequent sore throat	Abdominal pains	Tires easily
Poor vision	Frequent urination	Shortness of breath
Frequent leg pains	Allergy	Hernia (rupture)
Dizziness	Persistent cough	Ringworm
Frequent sties	Speech difficulty	Nose bleeding
Dental defects	Crippling conditions	Growing pains
Does your child have a disability due to disease or accident?		
Has your child had a skin test for tuberculosis?		Date administered
Has he been associated with a tubercular patient?		When?
PERSONAL RECORD – Please answer all of the following.		
Is he/she shy?	Overactive?	Bite fingernails?
Suck thumb?	Have excessive fears?	Have temper tantrums?
Like school?	Play well with others?	Eat breakfast?
When is his/her regular bedtime?	When is his/her rising time?	
Signature of Parent/Guardian		Date

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