STUDENT HEALTH FORM

INDEPENDENT STUDIES
2019-2020 SCHOOL YEAR

Mansfield Christian School 500 Logan Road Mansfield, OH 44907

REQUIRED IMMUNIZATIONS GRADES K-12

Note to Parents: Mansfield Christian School 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. (Attached please see the state requirements)

Name:			Date:
Phone:			Grade:
Home Address:	City		Zip:
Student Birthdate:			Sex:
Parent(s) or Legal Guardian:			
Indicate your child's past/present disease(s):			
___Heart	___Rheumatic Fever	___Diabetes	___Tuberculosis
___Epilepsy	___German Measles	___Old Fashioned Measles	___Mumps
___Chicken Pox	___ Asthma	___ Other	
Is your child on any medication? ___Yes ___No Please indicate the medication and reason for it being taken:			
Do any health and/or medical conditions require school restrictions, modifications, and /or intervention? ___Yes ___No. If Yes, please explain.			
Physical Activity: Limitations? ___Yes ___No If child has limitations, please send a note from your physician to the school.			
Does student have a physical handicap? ___Yes ___No Explain:		Has student ever had a convulsion? ___Yes ___No Explain:	
Is your child on a modified diet? _____ Type _____			
Does student have trouble with bladder control?___Yes ___No		Is student a bed wetter? ___Yes ___No	
Please state any health problems you wish the school to know about:		Would you say student is: __very active, __average, __quiet	
List dates and reasons of any hospitalizations:			
Please indicate any allergies your child may have:			

Allergy Type	**Reaction**	**School restrictions or recommended actions:**
□ Bee/Insect		
□ Food		
□ Medication		
□ Other		

Form completed by:	**Relationship to student**	**Date:**