

STUDENT HEALTH FORM

Kindergarten – 12th Grade
2019-2020 SCHOOL YEAR

Mansfield Christian School

500 Logan Road

Mansfield, OH 44907

REQUIRED IMMUNIZATIONS

Note to Parents: Mansfield Christian School requires a copy of your child's up to date 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. (Enclosed 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): | | |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> German Measles | <input type="checkbox"/> Old Fashioned Measles <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other |
| Is your child on any medication? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, please explain. | | |
| Physical Activity: Limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If child has limitations, please send a note from your physician to the school. | | |
| Does student have a physical handicap? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: | | Has student ever had a convulsion? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: |
| Is your child on a modified diet? _____ Type _____ | | |
| Does student have trouble with bladder control? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Is student a bed wetter? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Please state any health problems you wish the school to know about: | | Would you say student is: <input type="checkbox"/> very active <input type="checkbox"/> average <input type="checkbox"/> quiet |
| List dates and reasons of any hospitalizations: | | |
| Please indicate any allergies your child may have and the severity : | | |
| Allergy Type | Reaction | School restrictions or recommended actions: |
| <input type="checkbox"/> Bee/Insect | | |
| <input type="checkbox"/> Food | | |
| <input type="checkbox"/> Medication | | |
| <input type="checkbox"/> Other | | |
| Form completed by: | Relationship to student | Date: |