

# STUDENT HEALTH FORM

## INDEPENDENT STUDIES 2016-2017 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):		
<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: __very active, __average, __quiet
List dates and reasons of any hospitalizations:		
Please indicate any allergies your child may have:		
<b>Allergy Type</b>	<b>Reaction</b>	<b>School restrictions or recommended actions:</b>
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		
<b>Form completed by:</b>		<b>Relationship to student      Date:</b>