INSTRUCTIONS:
1. The top portion is to be completed by the parent. Please print clearly and answer all questions. This form is required by the state of Ohio. A listing of required immunizations is attached.
2. The remainder of this form must be completed by a physician for all students who are entering school for the first time or who have never had a pre-school physical. This includes all Kindergarten and Home-schooled students and students transferring from another school which did not require it. Parents may complete the entire form for other students.

First Baptist Christian School
Student Health Record

Child's name: _____ Date of Birth: _____

Home Address: _____ Home Phone: (_____)_____

Father's Name: _____ Place of Employment: _____

Father's Business Phone: (_____)_____ Address: _____

Mother's Name: _____ Place of Employment: _____

Mother's Business Phone: (_____)_____ Address: _____

Physician's name: _____ Phone number: (_____)_____

Physicians address: _____

IMMUNIZATIONS – ENTER MONTH, DAY, & YEAR

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
DPT, DTaP, DT					
POLIOMYELITIS					
HIB					
HEPATITIS B					
MMR					
TUBERCULIN					

( ) YES ( ) NO Is this child subject to conditions which may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, others? If yes, please explain: _____

( ) YES ( ) NO Does this child have any other medical problem with which the school should be concerned? If yes, please explain _____

( ) YES ( ) NO Is there evident need for Dental care? If yes, please explain: _____

( ) YES ( ) NO Is there any Hearing Defect for which the school could help compensate by seating or other action? If yes, please explain: _____

( ) YES ( ) NO Is there any vision defect for which the school could help compensate by seating or other action? If yes, please explain: _____

( ) YES ( ) NO Does any relative or anyone in the home have tuberculosis, diabetes, or other illness? If yes, please explain: _____

( ) YES ( ) NO Is there any mental, emotional, or physical condition, for which the child should remain under your periodic observation? If yes, please explain: _____

( ) YES ( ) NO Is there any reason why the student cannot carry out a full program of school work? If yes, please explain: _____

( ) YES ( ) NO Has the Preschool Vision Screening Test been passed (as required by law)? If no, please explain: _____

List diseases and other serious illness, injuries, or health conditions this child has had and please give dates (year only): _____

_____

_____

PHYSICIAN'S RECOMMENDATION: I hereby state that in my opinion _____ has been adequately immunized according to the Ohio State Immunization requirements.

Date _____ Signature of examining Physician: _____

Parent Signature (If information not given by physician): I hereby state that to the best of my knowledge, this health record is complete and accurate.

Date_____ Parent Signature: _____