TEMPLE CHRISTIAN ACADEMY
Medical History Form

It is mandatory that pupils who show symptoms of a communicable disease be excluded from classes until re-admission is acceptable to the school administration. Your cooperation is greatly appreciated.

Student's Name _____ Birthday _____ Sex _____

PAST DISEASES – If your child has had any of the following, please state the age when he/she had them.

Measles _____	Diphtheria _____	Polio _____
Mumps _____	Scarlet Fever _____	Convulsions _____
Whooping Cough _____	Rheumatic Fever _____	Heart Disease _____
Asthma _____	Chicken Pox _____	Discharging Ears _____
Syphilis _____	Gonorrhea _____	Diabetes _____
Hay Fever _____	Pneumonia _____	HIV (Aids) _____

RECENT DISABILITIES – Please check any of the following as applicable.

Frequent Colds _____	Fainting Spells _____	Hearing Difficulty _____
Frequent Sore Throat _____	Abdominal Pains _____	Tires Easily _____
Poor Vision _____	Frequent Urination _____	Breath Shortness _____
Frequent Leg Pain _____	Allergy _____	Hernia (rupture) _____
Dizziness _____	Persistent Cough _____	Ringworm _____
Frequent Sties _____	Speech Difficulty _____	Nose Bleeding _____
Dental Defects _____	Crippling Conditions _____	Growing Pains _____

PERSONAL RECORD – Please answer all of the following.

Is he shy? _____	Overactive? _____	Bites fingernails? _____
Sucks thumb? _____	Has excessive fears? _____	Has temper tantrums? _____
Likes school? _____	Plays well with others? _____	Eats breakfast? _____

Does your child have a disability due to disease or accident? _____

Has your child had a skin test for tuberculosis? _____ Date _____

Has he been associated with a tubercular patient? _____

Parent's Signature _____ Date _____