Three Sisters Adventist Christian School
Student Medical Record
20__/20__ School Year

Name: _____ Grade: _____ DOB: _____

Student Health Evaluation

1. Does your student have a physical handicap? **YES** **NO**
   If yes, please state nature of condition:

2. Has your student ever had an operation? **YES** **NO**
   If yes, please state nature of operation and date performed:

3. Has your student ever had a severe injury? **YES** **NO**
   If yes, please explain and give date of injury:

Medical History (Please check all of the following your child has or has experienced in the past):

1. Head or neck injuries Yes:____ Year:_____
2. Muscle, bone or join disease Yes:____ Year:_____
3. Vision impairment Yes:____ Year:_____
4. Hearing problem Yes:____ Year:_____
5. Speech problem Yes:____ Year:_____
6. Diabetes Yes:____ Year:_____
7. Epilepsy or other seizure disorder Yes:____ Year:_____
8. Kidney disease Yes:____ Year:_____
9. Rheumatic or scarlet fever Yes:____ Year:_____
10. Heart disease/problems Yes:____ Year:_____
11. Food/drug allergies Yes:____ Year:_____
12. Bee sting allergy Yes:____ Year:_____
13. Other allergies Yes:____ Year:_____
14. Asthma/lung disease Yes:____ Year:_____
15. Exposure to tuberculosis Yes:____ Year:_____
16. Currently taking medication Yes:____ Year:_____
17. Please explain all "yes" responses. Describe other conditions that might require special consideration at school. Please attach additional documentation as needed.

_____

_____

_____

_____ _____

Parent/guardian signature Date