Carlisle Christian Academy

Health Registration Form

*Family Information to be completed by the **Parent** or **Guardian***

Name ___________________________________ Sex ______ Birthdate _________

Address ____

Father's Name ____

Employer _________________________________ Business Phone _________________

Mother's Name ____

Employer _________________________________ Business Phone _________________

Medical History of Student

Mark an **X** by those that apply

____ Allergies (specify)
____ Asthma
____ Epilepsy
____ Accidents (yr)
____ Serious Illnesses (yr)
____ Speech Difficulties
____ Hepatitis (date)
____ Hernia (site)
____ Cancer
____ Measles (date)
____ Mumps (date)
____ TB
____ Treatment for Allergies
____ Diabetes
____ Operations (yr)
____ Physical (yr)
____ Physical Handicaps
____ Arthritis (type)
____ Anemia
____ German measles (date)
____ Chicken Pox (date)
____ Drug Addiction
____ Heart Disease
____ Cleft Palate

According to the school law of Pennsylvania the Department of Health mandates that each child should have a physical exam on original entry to school grade K and grades 6 and 11 or upon entry to Pennsylvania. Dental exams are mandated for original entry in grade K and in grades 3 and 7.

Health History

1. Is your child going to a doctor, hospital, or clinic right now? Yes___ No ____
   What for? ____

2. Apart from vitamins, is your child taking any medications, tablets or drops? Yes ___ No____
   What? ______________________________ Why? __________________

3. Has your child had any convulsions, seizures, fits? Yes___ No ____

4. Does your child have any special health problems? Yes___ No ____

5. Does your child need a special diet or have any food problems? Yes___ No ____
   Specify ____

6. Does your child require corrective lens? Yes___ No_____

Family History

1. **Circle** any of the following that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:

Allergies	Asthma	Cancer	Drug or alcohol addiction
Diabetes	Heart Disease	Seizures	Nervous breakdown
Tuberculosis	Lead Poisoning		Mental Retardation
Sickle Cell trait `	Other inherited or family diseases		

2. Has there been a recent death in the family? Yes____ No____

3. How many members of the family live in the same house as the child? ___________________
Their relationship to the child ____

Family Physician ____

Phone Number ____

Dentist ____

Phone Number ____

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Please indicate one of the following:

Physical appointment has been made for ______________________________ (date).
Name of doctor ____

Schedule the physical with the school physician.

Dental appointment has been made for ______________________________ (date).
Name of dentist _______________________________________

Schedule the dental exam with the school dentist.

_______________________ ______________________________________
Date Signature of Parent or Guardian