

COMMUNITY CHRISTIAN SCHOOL

500 Elks Rd.
 Richmond, IN 47374
 765.935.3215
www.ccsrichmond.com

C.C.S. Mission Statement:

"To assist students in partnership with their families, to successfully prepare for high school through excellence in a Christ-centered, academic environment."

HEALTH EXAMINATION FORM

(Must be signed by your child's physician)

Student's Name Birth Date

Student Address Phone

City State Zip

MEDICAL HISTORY

(To be completed by parent/guardian – please complete before child is examined by physician)

Yes No

1. Do you have any concerns about your child's general health (overall eating, sleeping habits, teeth, etc.)?
2. Has your child been diagnosed with any chronic disease? asthma diabetes seizure disorder others _____
3. Does your child have any allergies (food, insects, medications, latex, etc.)?
4. Does your child take any medications (daily or occasionally)?
5. Does your child have any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Has your child had any hospitalization, operation, major illness, or injury, or significant accident? Please specify _____
7. In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing, or excessive night Waking? Please specify. _____
8. In the last 12 months, has your child experienced any difficulty with excessive weight loss or gain, excessive thirst or urination? Please specify. _____

Minimum Immunization Requirements for Entry into School

	3-6 yr	K	1 st	2 nd	3 rd	4 th	5 th	6 th	7 th	8 th	9 th
DTaP/DTP/DT/Td*	4	5	5	5	5	5	5	5	5	5	5
Polio**	3	4***	4	4	4	4	4	4	4	4	4
Measles	1	2	2	2	2	2	2	2	2	2	2
Mumps	1	2	2	2	2	2	2	2	2	2	2
Rubella	1	1	1	1	1	1	1	1	1	1	1
Hepatitis B~	3	3	3	3	3	3	3	3	3	3	3
Varicella ∞	2	2	1	1	1	1	1	2	2	2	2
Tdap	-	-	-	-	-	-	-	1	1	1	1
MCV4	-	-	-	-	-	-	-	1	1	1	1

* Four doses of DTaP/DTP/DT are acceptable if 4th dose was administered on or after child's fourth birthday.
 **Three doses of polio vaccine are acceptable if 3rd dose was administered on or after child's fourth birthday and the doses are all IPV or all OPV
 ***The 4th dose of polio vaccine must be administered on or after child's fourth birthday. **This applies only to kindergarten for 2010-2011**
 ~ Two dose alternative adolescent schedule (Recombivax HB given at age 11-15 years x 2 doses) is acceptable if properly documented.
 ∞ Physician documentation of disease history, including month and year, is proof of immunity for preschool, kindergarten and 1st grade-students. A signed statement from the parent/guardian indicating history of disease, including month and year is required for children in grades 2-12.

CHILD PHYSICAL EXAMINATION HEALTH RECORD FORM

(Must be signed by your child's physician)

CONDITIONS:

Allergies
Physical Defects:
Use of any drugs/medications:
Why:
Other:

PHYSICAL EXAMINATION:

Skin		
Lymph Nodes		
Vision	Right	Left
Eyes		
Ears		
Hearing	Right	Left
Nose & Throat		
Teeth & Mouth		
Heart		
Blood Pressure	Height	Weight:
Lungs		
Abdomen		
Genitalia		
Other		

Chronic Disease Assessment

Yes	No		Date of Onset
<input type="checkbox"/>	<input type="checkbox"/>	Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II	_____
<input type="checkbox"/>	<input type="checkbox"/>	Anaphylactic Reaction: <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other: Please specify _____	_____

This student has the following problems which may adversely affect his or her educational experience:

- Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
- The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis.
- The pupil is on long-term medication.
- This student may participate fully in the school program, including physical education activities.
- This student may participate in the school program and physical education with the following restrictions/adaptation.

Comments: _____

Date of Exam _____ Physician Signature _____