

### Family Information

Student's Name (Last, First, Middle)		Date of Birth	Sex
Father's Occupation		Mother's Occupation	
Father's General Health		If deceased, cause:	
Mother's General Health		If deceased, cause:	

### History: If your student has had any of the following, please stage age when diagnosed.

Mumps	Diphtheria	Polio
Measles	Scarlet Fever	Convulsions
Whooping Cough	Rheumatic Fever	Heart Disease
Asthma	Chicken Pox	Diabetes
Hay Fever	Pneumonia	Discharging Ears
Syphilis	Gonorrhea	Other: Please Describe.
Has your student had a skin test for tuberculosis?		Date Administered?
Has your student been associated with a tuberculosis patient?		When?
Has your student been diagnosed with AIDS?		When?

### Personal Record

Is he/she shy?	Overactive?	Bite fingernails?
Suck thumb?	Have excessive fears?	Have temper tantrums?
Like school?	Play well with others?	Eat breakfast?
When is his/her regular bedtime?		When is his/her rising time?

Recent Disabilities Please check any one of the following noted recently.

Four or more colds yearly	Fainting spells	Hearing difficulty
Frequent sore throat	Abdominal pain	Tires easily
Poor vision	Frequent urination	Breath shortness
Frequent leg pains	Allergy	Hernia (rupture)
Dizziness	Persistent cough	Ring worm
Frequent sties	Speech difficulty	Nose bleeding
Dental defect	Crippling conditions	Growing pains
Does your student have a disability due to a disease or accident? Please explain.		

### Immunization Record

Vaccine	Date	Date	Date	Date	Date
DTP					
TD or Tetanus					
Polio, Oral					
Rubeola (Measles)					
Mumps					
Rubella (German measles)					

IT IS MANDATORY that students who show symptoms of communicable diseases be excluded from classes until readmission is acceptable to the Academy's educational leaders. Your cooperation will be greatly appreciated. Thank You!

Signature of Parent		Date	
Signature of Physician		Date	Phone Number

REMINDER: No student will be excused from Physical Education classes without a written permit from a physician.