



# MINTZ CHRISTIAN ACADEMY

2741 Mintz Road ♦ Roseboro, NC 28382 ♦ (910) 564-6221 Office ♦ [www.mcanc.com](http://www.mcanc.com)

## STUDENT MEDICAL FORM

School Year: 20\_\_\_\_ - 20\_\_\_\_

Student: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### A. MEDICAL HISTORY (To be completed by the parent)

1. Is your child allergic to anything? Yes No

If yes, what? \_\_\_\_\_

2. Is your child under a doctor's care? Yes No

If yes, what? \_\_\_\_\_

3. Any previous hospitalizations or operations? Yes No

If yes, what? \_\_\_\_\_

4. Is your child on any continuous medication? Yes No

If yes, what? \_\_\_\_\_

5. Any history of diseases or recurrent illnesses? Yes No

If yes, what? \_\_\_\_\_

6. Does your child have any physical disabilities? Yes No

If yes, what? \_\_\_\_\_

7. Does your child have any mental disabilities? Yes No

If yes, what? \_\_\_\_\_

### B. WHERE DOES YOUR CHILD RECEIVE HEALTHCARE?

Name of doctor/clinic: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Name of dentist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_

**C. PHYSICAL EXAMINATION** (To be completed by a licensed physician, certified nurse practitioner, or public health nurse)

Height \_\_\_\_\_ % Weight \_\_\_\_\_ % Head \_\_\_\_\_ Eyes \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_ Both Ears \_\_\_\_\_

Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abd/GU \_\_\_\_\_

Ext \_\_\_\_\_ Skin \_\_\_\_\_ Neurological \_\_\_\_\_ System \_\_\_\_\_ Should activities be limited? \_\_\_\_\_

Explain: \_\_\_\_\_

Results of Tuberculin Test, if give: Type \_\_\_\_\_ Date \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

\_\_\_\_\_  
Examiner's Signature/Title

\_\_\_\_\_  
Phone

**D. IMMUNIZATION RECORD** (the health official must enter the date immunizations were received in the space below or attach a copy of the immunization record.)

TYPE OF VACCINE	#1	#2	#3	#4	#5
*DPT OR DT (circle one)					
*Polio					
** Hib					
*MMR (combined doses)					
*** Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
*** Hep. B (three doses)					
Other					

\*Required by State Law \*\*Required by State Law if born on or after 10-01-91 \*\*\*Required by State Law if born on or after 7-01-94

**NOTE: If there are any changes in a student's health history, it is the responsibility of the parent/guardian to notify the school and submit a new "Student Medical Form" as soon as possible.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date