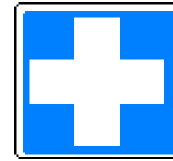
BATESVILLE COMMUNITY SCHOOL CORPORATION

HEALTH HISTORY



* Please return on or before the first day of school.

Name ___________________________________

Date of Birth ______________________________

Address ___________________________________

____

Phone ____________________________________

Parent(s) _________________________________

Weight ____________ Height _______________

Vision: Right 20 /_______ Left 20 /__________

Ears: Right 15 / _______ Left 15 /__________

B/P ______________________________________

IMMUNIZATION HISTORY (Mo./Day/Year)

DTaP 1) ________ 2) ________ 3) ________
Booster Dates 4) _________ 5) _________

Polio 1) ________ 2) _______ 3) ________
Booster Dates 4) __________

Hib 1)_______ 2)_______ 3)_______ 4)_______

HepB 1)________ 2)________ 3)________

Varicella 1)________ 2)________
Chicken Pox disease (Date) ______________

MMR 1)__________ 2)__________

Past Medical History

Chronic Illness ________________________________

____

Current Meds at Home _________________________

____

Meds for School _______________________________

____

Allergies _____________________________________

Dietary Restrictions ____________________________

Developmental Concerns ________________________

____

Restriction from physical activity Yes ____ No _____

Reason ______________________________________

Previous/Current OT/PT, Speech Therapy

____

____

Psycho Social Concerns _________________________

____

Physical Exam ( ) Normal

( ) Concerns __________________________________

Recommendations Prior to Starting Kindergarten

____

( ) None

Date: ______________________________

Physician Signature ____________________________________ (Printed) _________________________________

Address: ____

* *

DENTAL EXAMINATION

Name of Child ____ Date ______________________

Comments or recommendations:

Examining Dentist ____________________________________ (Printed) __________________________________

Address: ____