

HERITAGE HOME SCHOOL ACADEMY

Medical History

Pupil's Name _____ Birth Date _____ Sex _____
Father's Occupation _____ Mother's Occupation _____
Father's Health _____ If deceased, cause _____
Mother's Health _____ If deceased, cause _____

PAST DISEASES - If your child has had any of the following, state age when he had them.

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

RECENT DISABILITIES - Please check any one of the following noted recently.

4+ colds yearly _____	Fainting spells _____	Hearing difficulty _____
Frequent sore throat _____	Abdominal pains _____	Tires Easily _____
Poor vision _____	Frequent urination _____	Breath shortness _____
Frequent leg pain _____	Allergy _____	Hernia _____
Dizziness _____	Persistent cough _____	Ring worm _____
Frequent sties _____	Speech difficulty _____	Nose bleeding _____
Dental defects _____	Crippling Conditions _____	Growing pains _____

Does your child have a disability due to disease or accident? _____

IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE
DTP					
TD/TETANUS					
POLIO, oral					
RUBEOLA (measles)					
MUMPS					
RUBELLA (German measles)					

PERSONAL RECORD - (Please answer all of the following.)

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? _____

Date _____ Signature of Parent _____