

GENERAL HEALTH QUESTIONNAIRE

Christian Academy In Mozambique

To Parents and Guardians:

The following information is needed for the school records. Please be accurate as possible. Please do not leave any spaces blank, but draw a line in the space or write N/A in spaces not relating to you. Thank You.

Student's Full Name: _____

1. Are there any remarks regarding your child's health or development you would like to call to our attention ? (Epilepsy, hemophilia, diabetes, etc.)

2. Does your child have any mental or emotional problems ? Explain:

IMMUNIZATION RECORD

DTP (Diphtheria, Tetanus & Pertussis): Yes No
Dates of each: 1. _____ 4. "B" _____
2. _____ 5. "B" _____
3. _____

OPV (Oral Polio Vaccine): Yes No
Dates of each: 1. _____ 4. "B" _____
2. _____ 5. "B" _____
3. _____

MMR (Measles, Mumps & Rubella): Yes No
Dates of each: 1. _____ 4. "B" _____
2. _____ 5. "B" _____
3. _____

MEDICAL EXAMINATIONS

Date of Most Recent Physical Exam: _____ by Dr. _____

Date of Most Recent Dental Exam: _____ by Dr. _____

Date of Most Recent Eye Exam: _____ by Dr. _____

Does your child have 4 or more colds a year? _____

Does he/she have frequent ear infections? _____

Does he/she have allergies? _____

Does he/she have frequent bouts with pneumonia? _____

Is he/she on any special medications? _____ If so, name of medication _____

Please list any operations, injuries, or deformities: _____

Parent Signature: _____; Date _____