General Information

Name of Child _____ Sex _____ Birth Date _____
First Middle Last

Name of Parent _____ Best contact number_____-_____-_____

Address of Parent _____
Street City State – Zip

Medical History

1. Is child allergic to anything? Yes _____ No _____ If yes, please explain: _____
_____

2. Any previous history of the following:

_____Asthma	_____Epilepsy	_____Rheumatic Fever	_____Seizures
_____Diabetes	_____Frequent Sore Throat	_____Hay Fever	_____Heart Trouble
_____Ear Infection	_____Frequent Headaches	_____Scarlet Fever	_____Breathing Problems

3. Any physical or speech handicaps? Yes _____ No _____ If yes, please describe: _____
_____

4. Is child under the care of a doctor? Yes _____ No _____ If yes, for what reason? _____
_____

5. Any additional information that would be of help to the school? (such as play, eating/sleeping habits, fears, likes/dislikes)
_____

Emergency Care

In case of serious illness or injury at school and you cannot be reached, please list:

Your family physician: _____
Doctor's Full Name Phone Number

Hospital Preference: _____

Who will assume responsibility for payment of physician's or hospital care? _____

Health Insurance Co. _____ Policy/ID Number _____

Your family dentist: _____
Doctor's Full Name Phone Number

If neither parent/guardian can be reached for an emergency, call:

_____
Name Relation to child Best Contact Number

_____
Name Relation to child Best Contact Number

In case of *minor* headache or discomfort, permission is granted to give _____(Student's Name)

Ibuprofen _____ Saline Solution _____ First Aid Ointment _____
Tylenol _____ Tums _____ Throat Spray/Drops _____

Please note: Over-the-counter medications will be given based on the manufactures directions and only with permission from a parent/guardian.

It is understood that parents will hold ACS harmless for administering medicine as directed by parents.

By my signature below, I affirm that the above information is correct and grant Alamance Christian School permission to act on my behalf to arrange for emergency treatment and/or transportation for my child if I am unable to be reached in an emergency. I will notify the school office of any changes in this information during the time my child is enrolled at ACS.

Signature of Parent/Guardian _____ **Date** _____

To Be Completed For Pre-school, Kindergarten or 1st time Enrollment in School

Physical Examination (Must be completed and signed by examining physician within six months prior to enrollment.)

Weight _____ Height _____ Heart _____ Hernia _____ Chest _____

Throat _____ Neck _____ Abdomen _____ GU _____ Ext. _____ Feet _____

Neurological _____

Teeth _____ Skin _____ Head _____ Eyes _____ Ears _____ Nose _____

Results of Tuberculin Test, If given: _____
Types Results

Should activities be limited? _____

Other findings: _____

Recommendations: _____

Immunization History (Enter date each immunization received)

DTP* 1_____ 2_____ 3_____ 4_____ 5_____

*State law requires three DTP vaccines by age one; two booster doses, one the second year of life and the second to be administered on or after the fourth birthday and before enrolling in school (K-1) for the first time. If the fourth dose was administered after the fourth birthday, the fifth dose is not required.

Tdap (Booster) _____ Meningococcal _____ (both required for 7th grade enrollment)

POLIO* 1_____ 2_____ 3_____ 4_____

*Three doses of Oral Polio are required by age two and a booster dose on or after the fourth birthday and before enrolling in school (K-1) for the first time. If the third dose was administered after the fourth birthday, the fourth dose is not required.

MEASLES/MUMPS/RUBELLA (MMR) 1_____ 2_____

*A measles vaccine (MMR) is required before age two. Re-vaccination is required when a child was immunized even on day before age one. MMR #2 is required before entering Kindergarten for the first time

HIB* 1_____ 2_____ 3_____ 4_____

*Required for all children entering school who were born after 10-01-88, however, no individual who has passed their fifth birthday shall be required to be vaccinated against Hemophilus Influenza.

Hepatitis B (HBV)* 1_____ 2_____ 3_____

*Required by law for children born after 7-01-94.

VARICELLA (Chicken Pox) 1 _____ 2_____

Pneumococcal Conjugate (PCV) 1_____ 2_____ 3_____ 4_____

I hereby certify that this child has been examined and is physically fit to attend school and that the child has received the immunizations noted above.

_____ _____
Physician's Signature Date of Examination

_____
Office Address

_____
Telephone Number