



Calvary Baptist School
 N84W19049 Menomonee Avenue
 Menomonee Falls, WI 53051



Medical Record - Parent
 Confidential

Student Information

Date of Birth:

Legal Name

Last

First

Middle

Emergency Parent Contact:

Name of Physician:

Phone Number:

Phone Number:

Two names/contact numbers other than immediate family who can be reached in case of an emergency:

Name:

Phone Number:

Name:

Phone Number:

Medical History

Give the approximate year in which the student had any of the following:

Condition	Year	Condition	Year
Amoebic Dystentery		Pleurisy	
Appendicitis		Poliomyelitis	
Asthma		Pneumonia	
Chicken Pox		Red Measles	
Diabetes		Rheumatic Fever	
Diphtheria		Scarlet Fever	
Epilepsy		Skin Disease	
German Measles		Tonsillitis	
Hepatitis		Tuberculosis	
Infectious Mononucleosis		Typhoid Fever	
Influenza		Ulcers	
Kidney Infection		Venereal Disease	
Malaria		Whooping Cough	

Is the student subject to any of the following:

Condition	Yes	No	Condition	Yes	No
Hay Fever			Loss of weight		
Sore throat, colds			Loss of appetite		
Fainting spells			Fatigue		
Shortness of breath			Nervous disorders		
Constipation			Sinus problems		
Digestive disturbances			Eye strain		

Injuries or surgery:

Broken bones	When?	Type _____
Tonsillectomy	When?	
Appendectomy	When?	
Other	When?	Type _____

Family History

Is father living? Deceased _____
If deceased, cause of death:

Is mother living? Deceased _____
If deceased, cause of death:

Numbers of brothers: Number of sisters: Any deceased?
If deceased, cause of death:

Current Health

Does the student have any known allergies? Please list.

Any dietary problems? Please list.

Is the student on any prescription medication? If so, please describe:

Does the student regularly use any over-the-counter medication? If so, please list and give reason for use:

Has the student ever had any reaction to a drug or antibiotic? If so, name drug and reaction.

Does the student have any serious handicap? If so, please describe:

I hereby certify that the above information is complete to the best of my knowledge. I authorize Calvary Baptist School to secure medical treatment wherever possible, if I cannot be reached.

Parent/Guardian Signature

Date