Macedonian Christian Academy
(956) 464-7950

MEDICAL HISTORY

IT IS MANDATORY that pupils who show symptoms of communicable disease be excluded from classes until readmission is acceptable to the School's Educational leaders. Your cooperation will be greatly appreciated. Thank you!

Pupil's Name:________________________________ Birth Date:________________

Father's Occupation:____

Mother's Occupation:____

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

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

❑ 4 or more colds yearly	❑ Fainting spells	❑ Hearing difficulty
❑ Frequent sore throat	❑ Abdominal pains	❑ Tires easily
❑ Poor vision	❑ Frequent urination	❑ Breath shortness
❑ Frequent leg pains	❑ Allergy	❑ Ringworm
❑ Dizziness	❑ Persistent cough	❑ Hernia(ruptures)
❑ Frequent sties	❑ Speech difficulty	❑ Nose bleed
❑ Dental defects	❑ Crippling conditions	❑ Growing pains

IMMUNIZATION RECORD (Please attach copy of immunization record.)

PERSONAL RECORD (Please answer all of the following.)

Is h/she shy? ❑ Yes ❑ No   Overactive? ❑ Yes ❑ No   Bite fingernails? ❑ Yes ❑ No

Suck thumb? ❑ Yes ❑ No   Have excessive fears? ❑ Yes ❑ No   Have temper tantrums? ❑ Yes ❑ No

Like school? ❑ Yes ❑ No   Play well with others? ❑ Yes ❑ No   Eat breakfast? ❑ Yes ❑ No

When is his/her regular bedtime?____________________ When is his/her rising time?____________________

SIGNATURE OF PARENT:____ DATE:__________________

STUDENT INSURANCE RECORD

Name of Company:____

Policy Number:____

Address:____

Effective Date:________________________

Expiration Date:_______________________