Cypress Bend Adventist School

2997 FM 728
Jefferson TX 75657
903-665-7402

Student Medical History Record

Student's Name _____ Date of Birth _____ Sex_____

Home Address _____ U.S. Citizen_____ Nationality_____

_____ Home Telephone _____

Father's Name _____ Home Telephone _____

Address _____ Work Telephone _____

Mother's Name_____ Home Telephone _____

Address _____ Work Telephone _____

Legal Guardian _____ Home Telephone _____

Address _____ Work Telephone _____

Does student live with:_____ Both parents_____ Mother_____ Father _____ Other

Language spoken in home_____

1. Past Illnesses (Please check those the student has had)

_____ Anemia
_____ Anorexia
_____ Asthma/Hay Fever
_____ Bleeding Disorders
_____ Chicken Pox
_____ Diabetes
_____ Epilepsy
_____ Fainting Disorders
_____ Frequent Colds
_____ Heart Disease
_____ Hepatitis
_____ Kidney (Bladder Disorders)
_____ Malignancies
_____ Measles
_____ Migraine Headaches
_____ Mumps
_____ Polio
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Tuberculosis

2. List any other serious illnesses, operations, or injuries and age when occurred:

_____

_____

3. Does student have allergies? Yes/No Medications? Yes/No Other? Yes/No

Please list: _____

4. Does student have a hearing defect? Yes/No Date of last examination:_____

Explain: _____

5. Does student have vision problems? Yes/No Has it been corrected? Yes/No

Explain: _____

Date of Last examination: _____

6. Does student have any physical defects? Yes/No

   Explain: _____

7. Does student have any mental defects? Yes/No

   Explain: _____

8. Does student have any other defects or limitations that would limit student's participation in classroom activities? yes n In physical education? Yes/No

   Explain: _____

9. List all current medications: _____

   _____

10. List any medication that student would be required to take during school hours, and when:

    _____

    _____

11. Whom to notify in case of emergency or illness:

    Name A _____ B _____

    Address _____ _____

    Phone _____ _____

12. Student's physician: Name_____ Phone _____

    Alternate physician: Name _____ Phone _____

13. Does student have insurance coverage? Yes/No

    Company:_____ Policy No.:_____

14. Do you consent to your child being given emergency attention in a hospital or by a competent physician if necessary? Yes/No

Parent's Name (please print) _____

Signature _____

Date _____