Hammond Baptist Schools

A Ministry of the First Baptist Church of Hammond, Indiana

134 West Joliet Street, Schererville, Indiana 46375

HEALTH RECORD

Name _____ Date of Birth ____/____/____ Grade _____

Address _____ Male ___ Female ___ Age _____

Street City State Zip

Father's name _____ Work phone (_____)_____

Mother's name _____ Work phone (_____)_____

Mother's phone (_____)_____Father's phone (_____)_____

Physician _____ Phone (_____)_____

IMMUNIZATIONS: The immunizations below are required by law.					
	Month - Day - Year	Month - Day - Year	Month - Day - Year	Month - Day - Year	Month - Day - Year
DTap/DTP/DT/Td (4 for JK, 5 for SK through grade 12)					
Tdap Booster (1 after 10 years of age, grade 6-12)					
Polio (3 for JK, 4 for SK through grade 12)					
MMR (1 for JK, 2 for SK through grade 12)					
Hepatitis B (3 for JK through grade 12)					
Varicella (1 for JK, 2 for SK through grade 12, or history of disease)					
History of Chicken Pox disease: Had disease: Month: _____ Year: _____	Physician's signature: _____Parent's signature: _____				
Meningococcal (MCV4 / Menactra) (1 for grade 6-10, 2 for grade 11 and 12)					
Hepatitis A (2 for SK)					
Other					

HISTORY											
Have you *EVER* had:	Yes	No	**Have you *EVER* had:**	Yes	No	**Do you *NOW* have:**	Yes	No	**Do you *NOW* have:**	Yes	No
Fainting			Kidney Disease			Blurred Vision			Nosebleeds		
Diphtheria			Tuberculosis			Recurring Headaches			Frequent Sore Throat		
Scarlet Fever			Jaundice			Fainting			Stomach Pains		
Rheumatism			Chicken Pox			Convulsions			Recurring Skin Conditions		
Rupture / Hernia			Rubella (German Measles)			Blackouts			Asthma		
Rheumatic Fever			Measles (Rubeola)			Painful Joints			Frequent Diarrhea		
Poliomyelitis			Mumps			Backaches			Frequent Constipation		
Pneumonia			Convulsions			Pounding of Heart			Orthopedic Problems		
Asthma			Allergy (specify)			Shortness of Breath			Allergy (specify)		
Diabetes			Drug / Alcohol / Tobacco Usage			Frequency of Urination			Drug / Alcohol / Tobacco Usage		
Heart Disease			Other (specify)			Cough			Other (specify)		

Operations (specify) _____

Serious Accidents _____

FAMILY HISTORY: *Give state of health or cause of death for:*

Mother _____ Father _____ Sisters _____ Brothers _____

Sickness in the home (describe) _____

MEDICAL INFORMATION

(Completed by physician)

PHYSICAL EXAMINATION

Name _____ Grade _____ Age _____ Sex _____ Height _____ Weight _____
B/P _____/_____ Temperature _____ Pulse _____ Respirations _____

Skin _____ Any recurring problems? _____

Head
Hair and scalp _____
Eye abnormalities _____ Vision _____ Left _____ Right _____
Ear abnormalities _____ Hearing _____ Left _____ Right _____

Nose and Throat
Palpable nodes _____
Tonsils _____

Chest
Lungs _____
Heart _____

Abdomen: Hernia *(inguinal; femoral; umbilical; other)* _____

Extremities _____

Orthopedic Defects _____

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( ) I recommend a ***regular*** program of activity, which includes the following:
Boys - Basketball, soccer, track, wrestling, volleyball, gym hockey, football, dodgeball, rugby, baseball, etc.
Girls - Tumbling, basketball, volleyball, gymnastics, soccer, track, badminton, dodgeball, rugby, softball, etc.

( ) I recommend a ****modified*** program of physical activity. (Specify degree and reason below)
Restricted physical education includes less strenuous activities such as: ping pong, walking, throwing, officiating and score-keeping.

Comments and recommendations _____
_____

***Recommendations for modified activity are effective for the current school year only.**

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Any other information not covered above _____
_____
_____
_____
Other comments _____
_____

Date _____ **Signature** _____

Address _____

City, State, & Zip _____ Phone (_____)_____