

WOODLAND CHRISTIAN SCHOOL
1616 West Street • Woodland, CA 95695 • (530) 666-6615

HEALTH INFORMATION
TO BE COMPLETED BY THE PARENT(S)

NAME OF STUDENT _____ LAST SCHOOL ATTENDED _____
PARENT'S NAME _____ PHONE _____
ADDRESS _____
FAMILY DOCTOR _____ CITY _____ PHONE _____

Medical History: PLEASE CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD:

_____ Diabetes	_____ Polio	_____ Whooping Cough
_____ Epilepsy	_____ Pneumonia	_____ Measles (regular - 10 day)
_____ Heart Disease	_____ Chicken Pox	_____ Allergies - Explain: _____
_____ Rheumatic Fever	_____ German Measles (3 day)	_____
_____ Tuberculosis	_____ Mumps	_____ Other (i.e., nosebleeds) _____
_____ Tuberculosis Contact	_____ Scarlet Fever	_____

Operations or serious injuries _____

Have any special recommendations been made by your physician concerning the school life of this child? _____

Has he/she ever worn glasses? _____ Does he/she at this time? _____

Has he/she ever had a hearing loss? _____ If so, explain _____

Are there any physical conditions requiring special attention: _____

Does he/she have medication prescribed or special routines which should be included and/or made known to the school:

PARENT SIGNATURE _____ DATE _____

BOTH SIDES OF FORM MUST BE COMPLETE. THANK YOU.