Milford Christian School

HEALTH & MEDICAL RECORD

Student Name: _____

Please circle those items below which pertain to your child and include any pertinent information that you think will be helpful to the school including allergies, accidents or surgeries.

Allergies	Frequent Colds	Mumps	Tonsillitis
Asthma	Hearing Difficulty	Orthopedic Issues	Tuberculosis
Chicken Pox	Heart Disorder	Rheumatic Fever	Vision Difficulty
Convulsive Disorder	Kidneys	Rubella	Whooping Cough
Diabetes	Measles	Speech Difficulty	Other ?

Comments:
_____
_____
_____
_____

Immunization Dates: Indicate the number of shots completed (either separately or combined and year of vaccination).

DPT SERIES (3 shots) - Year _____
Mumps - Year _____
Measles - Year _____
Rubella - Year _____
Polio (oral – number of doses_____) - Year _____

Latest Boosters:
DT - Year _____
Mumps - Year _____
Polio - Year _____

Tuberculin Test - Type _____ Results _____ Date _____

Parent's Signature: _____