Student Name_______________________________________ Grade____________________
Last First

GRACE Christian School
Immunization History/Health Assessment

Information must be completed by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for health check services. *Please Print clearly in black ink.*

I. *Personal Information*

Student's Name_______________________________________ DoB__________________ Sex_____________

Address____

Parents'/Guardians' Names____

Ethnicity ❒ Caucasian ❒ African American ❒ Hispanic ❒ Asian ❒ Other______________________

II. *Immunization Requirements:* Complete for NEW STUDENTS and RISING SIXTH GRADERS

VACCINE	DOSE #1	DOSE #2	DOSE #3	DOSE #4	DOSE #5	BOOSTER
DTaP, DTP, DT						
Polio						
Hib						
Hepatitis						
MMR						
Varicella						

North Carolina Department of Environment, Health, and Natural Resources requires the following minimum doses for all children entering school. A booster DTaP is required for children entering sixth grade.
DTaP, DTP, or DT-5 plus booster required before entering sixth grade (DT requires medical exemption)
Polio-4 (If third dose is after fourth birthday, fourth dose is not required)
Hib-4 (Series complete if at least one dose given on/after 15 months and before five years; not required after age five)
Hep B-3 (Children born on/after July 1, 1994 are required to have three doses)
MMR-2 of live attenuated vaccine; one in the second year of life and the second before enrolling in school for the first time
Varicella-1 (Children born on/after April 1, 2001, without documented history of the disease)

Exemptions from N.C. State Immunization Law require a statement to be on file in student's permanent record. Exemptions must meet requirements of the law. Please consult your local health department for details.
❒ Medical ❒ Religious Exemption

Student Name____ Grade_____________________
Last First

III. Health History

Health History Questions	Yes	No	Unsure
Has anyone in the student's family (grandparents, parents, siblings) died suddenly before age 50?			
Has student ever stopped exercise because of dizziness or passed out during exercise?			
Does student have asthma (wheezing), hay fever, or coughing spells after exercise?			
Has student ever broken a bone, had to wear a cast, or had an injury to any joint?			
Does student have a history of concussion (getting knocked out, unconscious)?			
Has student ever suffered heat related illness (heat stroke)?			
Does student have a chronic illness or see a doctor regularly for any particular problem?			
Does student take any medications?			
Is student allergic to any medications, foods, bee stings, etc.?			
Does student have only one of any paired organs (eyes, ears, kidneys, ovaries, testicles, etc.)			
Has student had an injury/illness in the last year that caused five/more consecutive absences?			
Has student had surgery or been hospitalized in the past year?			
Does student have a medical diagnosis that has not been resolved in the past year?			
Will any problem or condition affect athletic/school performance?			

If yes, please explain in detail____

IV. *Health Assessment*

Weight__________lbs

BMI for age is: ❒ Normal (5%<85%ile) ❒ At-Risk Overweight (85%<95%ile) ❒ Underweight (≤5&ile) ❒ Overweight (≥95%ile)

Height_____ft _____in

Blood Pressure_____

Vision	Right	Left	Both
Far	20/	20/	
Near			20/

Hearing	1000	2000	4000
Right			
Left			

Student Name____ Grade________________________
Last First

IV. *Health Assessment Continued*

	Normal	Abnormalities
Eyes		
Ears, Nose, Throat		
Mouth and Teeth		
Neck		
Cardiovascular		
Chest and Lungs		
Abdomen		
Skin		
Genitalia- Hernia (Male)		
Musculoskeletal ROM, Strength, Etc.		
Neck		
Spine		
Shoulders		
Arms/Hands		
Hips		
Thighs		
Knees		
Ankles		
Feet		
Neuromuscular		

Please Check if Child Experiences the following

- ❏ **Asthma**
- ❏ **Bleeding Problems**
- ❏ **Bowel Problems**
- ❏ **Cancer/Leukemia**
- ❏ **Attention/Learning**
- ❏ **Convulsions/Seizures**
- ❏ **Cystic Fibrosis**
- ❏ **Dental Problems**
- ❏ **Diabetes**
- ❏ **Emotional/Behavioral**
- ❏ **Ear Infections**
- ❏ **Heart Problems**
- ❏ **Meningitis**
- ❏ **Sickle Cell Anemia**
- ❏ **Vision Problems**
- ❏ **Skin Problems**
- ❏ **Speech Problems**
- ❏ **Stomach Aches**
- ❏ **Urinary/Bladder**
- ❏ **Other**______________________

Physical limitations/Athletic restrictions:____
____
____
____

Physician's Name____
Street Address____
City, State, Zip____
Telephone Number____

I certify that I have examined this student and found him/her medically qualified to participate in sports.

Physician's Signature_________________________________ Date__________________________