



LIVING WORD CHRISTIAN ACADEMY MEDICAL PROFILE

20 ____ - 20 ____

**This form is required to be completed by a *physician* for all new students.
Returning families are to update both sides of this form where necessary.**

Date of Examination:			
Child's Name			
Parents' Names	Father/Guardian:		
	Mother/Guardian:		
Child's Age:	Birth Date: ____/____/____	Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Allergies:			

Chronic Disorders: Check each disorder which applies.

ADD		Emotional Distress		Hyperactivity	
AIDS		Epilepsy		HIV+	
Anorexia		Headaches		Hypoglycemia	
Asthma		Heart Disease		Sensory Deficit	
Bulimia		Hepatitis		TB	
Diabetes		Herpes			
Eczema		Hypotension			
Other:					

Please write a brief history for each disorder; include DX, TX, RX for each disorder.

*Hearing Screening:	Pass		Fail		Referred to:
Treatment:					

Impedance	Right Ear	Left Ear	Audio	Right Ear	Left Ear
Compression			500		
Pressure			1000		
Volume			2000		
			4000		

*Vision Screening:	Snellen		Tumbling E		HOTV		Other
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Without Glasses:	R-20/		L-20/		With Glasses:	R-20/		L-20/	
Pass		Fail		Referred to:					
Treatment:									

***Screenings required for K4, K5, 1st, 3rd, 5th, 7th, and all new students. If the child is not screened by a physician, the school screening will be required.**

I hereby give permission for my child to be screened for vision and hearing by Living Word Christian Academy.

Signature of Parent/Guardian _____
Date

Scoliosis screen required for Grade 6. School screening will not be available.

I hereby certify this child to be free of communicable disease and physically and mentally able to attend school.

Restrictions: _____

_____ DO/MD
Physician's Signature

I hereby certify this child is physically able to participate in all physical education activities.

Restrictions: _____

_____ DO/MD
Physician's Signature

Immunization Records: Age _____ Date of Birth ____/____/____ **Please record dates of immunizations.**

DPT or DTaP (diphtheria/pertussis/tetanus)		Polio (oral vaccination)	
Four doses (last dose since age 4 and within past 10 years).		Three or four doses, depending on age of child.	
MMR (measles/mumps/rubella)		Tuberculosis	
One or two doses, depending on age of child.		Some districts require a skin test.	
Haemophilus Type B		Hepatitis B	
Three or four doses, depending on manufacturer of vaccine.		Three doses for students born after 9/1/92. Students born between 9/2/88, and 9/1/92, have until 30 days after 12th birthday to show proof of three doses.	
Chicken Pox			
One dose for students born after 9/1/94, or proof of having had the disease. Students born between 9/2/88, and 9/1/94, have until 30 days after 12th birthday to show proof of one dose or past infection.			

_____ DO/MD

Physician's Signature

THIS FORM MUST BE COMPLETELY FILLED OUT AND SIGNED BY THE PHYSICIAN BEFORE THE STUDENT WILL BE ADMITTED INTO LIVING WORD CHRISTIAN ACADEMY.

***(Exception: Those wishing school screening for vision and hearing.)**