

COASTAL CHRISTIAN HIGH SCHOOL
709 George Anderson Drive • Wilmington, NC 28412
(910) 395-9995 • admissions@coastalchristian.net

CONFIDENTIAL STUDENT MEDICAL FORM

Student Name: _____ Birth Date _____
LAST FIRST M. I. MONTH DAY YEAR

Name of Parent or Guardian _____

Mailing Address _____

City _____ State _____ Zip _____

A. Medical History (To be completed by the parent. Check all answers that apply.)

1. Does your child have any allergies? ___Yes ___No
 - a. If yes, please explain _____
 - b. List medications used _____
 - c. How is the medication dispensed and how often? _____
2. Is your child under a doctor's care? ___Yes ___No
 - a. If yes, please explain _____
 - b. Doctor's name or facility _____
3. Has your child had previous hospitalizations or surgeries? ___Yes ___No
 - a. If yes, please explain _____
 - b. Date of last hospitalization or surgery _____
4. Is your child on any continuous medication? ___Yes ___No
 - a. If yes, please explain _____
 - b. List medication, when and how it is dispensed _____
5. Does your child have any history of diseases or recurrent illness? ___Yes ___No
 - a. If yes, please describe (i.e. diabetes, convulsions, heart trouble, etc.) _____
6. Does your child have any physical disabilities? ___Yes ___No
 - a. If yes, please describe _____
7. Does your child have any mental disabilities? ___Yes ___No
 - a. If yes, please describe _____

B. Immunization Record: The health official must enter the date immunization was received in the space below or attach a copy of the immunization record.

TYPE OF VACCINE	#1	#2	#3	#4	#5
*DPT OR DT (<i>circle one</i>)					
*POLIO					
*Hib					
*MMR (combined doses)					
***Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
***Hep. B (three doses)					
Other					

*Required by State Law ** Required by State Law if born on or after 10-1-91

*** Required by State Law if born on or after 7-1-94

Health Official's Signature and Title _____ Date _____