_____ Birthdate_____Grade_____

LName First MI School_____

# HEALTH APPRAISAL FORM 2014-2015

Has Student a history of the following? Mark X only if yes and write remarks below

| | | | |
|---|---|---|---|
| **1. Chicken Pox** | | **14. Orthopedic problem** | |
| **2. Measles** | | **15. Convulsions or equivalent** | |
| **3. German Measles** | | **16. Other neurological disorder** | |
| **4. Mumps** | | **17. Emotional problems** | |
| **5. Allergy** | | **18. Accidents** | |
| **6. Eye problems** | | **19. Operations** | |
| **7. Ear problems** | | **20. Hospitalizations** | |
| **8. Pulmonary disease** | | **21. Other** | |
| **9. Cardiac disease** | | **22. Is student taking medication? If yes,** | |
| **10. Endocrine disorder** | | **explain below.** | |
| **11. Menstrual Disorder** | | | |
| **12. Kidney disease** | | | |
| **13. Congenital anomalies** | | | |

# IMMUNIZATION HISTORY

| | Initial Series Year | BOOSTERS Date | Date | | | Date | Result | Date | Result |
|---|---|---|---|---|---|---|---|---|---|
| **OPT** | | | | | **Small Pox** | | | | |
| **OT** | | | | | **TB Test** | | | | |
| **Tetanus** | | | | | **Chest Xray** | | | | |
| **Polio** | | | | | | | | | |
| **Measles** | | | | | | | | | |
| **Mumps** | | | | | | | | | |
| **Rubella** | | | | | | | | | |
| **Remarks:** | | | | | | | | | |

_____

To the best of my knowledge:

( ) My child is physically qualified to participate in the MCJROTC program.

( ) My child is physically qualified to participate in the MCJROTC program with the following limitations:

( ) My child is not physically qualified for the MCJROTC program.

**Parent's signature**_____**Date**_____