

LName First MI

Birthdate _____ Grade _____
School _____

HEALTH APPRAISAL FORM 2023-24

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, explain below.	
10. Endocrine disorder			
11. Menstrual Disorder			
12. Kidney disease			
13. Congenital anomalies			

IMMUNIZATION HISTORY

	Initial	BOOSTERS			Date	Result	Date	Result
	Series							
	Year	Date	Date					
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 _____