_____ Birthdate_____Grade_____

LName First MI School_____

24-25 HEALTH APPRAISAL FORM

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**_____