Birthdate_
School___

LName First MI

25-26 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	BOOSTERS							
	Year	Date	Date			Date	Result	Date	Re
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**_____

Grade