

KINSHASA CHRISTIAN SCHOOL

STUDENT'S HEALTH RECORDS

This Record is to be filled in by parent or guardian and turned into KCS at time of registration

LAST NAME	FIRST	INITIAL	BIRTHDATE	SEX
ADDRESS			PHONE	EMAIL
NAME OF FATHER			NAME OF MOTHER	

Has child had:	YES	NO
Allergies	🍏	🍏
Asthma	🍏	🍏
Breath-holding or temper tantrums	🍏	🍏
Bronchitis	🍏	🍏
Chickenpox	🍏	🍏
Convulsions or other seizures	🍏	🍏
Difficulty with toilet training or bedwetting	🍏	🍏
Frequent diarrhea	🍏	🍏
Frequent ear infections	🍏	🍏
Frequent sore throats	🍏	🍏
Frequent Vomiting	🍏	🍏
German Measles	🍏	🍏
Measles	🍏	🍏
Mumps	🍏	🍏
Nightmares or trouble sleeping	🍏	🍏
Pneumonia	🍏	🍏
Rheumatic fever	🍏	🍏
Tendency to bleed easily	🍏	🍏
Trouble with hearing	🍏	🍏
Trouble with speech	🍏	🍏
Trouble with vision	🍏	🍏
Unusual nervousness, nail biting or thumb sucking	🍏	🍏
Wheezing	🍏	🍏
Any SEVERE INJURY	🍏	🍏
Specify:		
Any SURGERY	🍏	🍏
Specify:		

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FAMILY HEALTH HISTORY

RELATIVE	Year of Birth	State of Health
Father		
Mother		
Sibling 1:		
Sibling 2:		
Sibling 3:		
Sibling 4:		
Sibling 5:		

Has any relative had:	Yes	No	Relative
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	
Significant allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information and explanation for any checked "YES"
