PLEASANT VALLEY BAPTIST SCHOOLS

13539 Garner Lane • Chico, California 95973 • (530) 343-0555

New Student Registration and Health Form

Student's Name _____ Grade Level ___ M ___ F ___
Last First Middle Nickname

Address _____ Home Phone_____
Street City Zip Code

Student's Age _____ Birthdate _____ Birth Place _____

Father's Name _____ Employer _____

Mother's Name _____ Employer _____

School last attended _____ Grade completed _____

School Address _____
Street City State Zip Code

Person to contact in case of emergency when parents cannot be reached:

Name _____ Phone _____

Please complete all health questions on both sides of this form.

IMMUNIZATION	YES	NO	DATE
Small Pox	___	___	_____
Whooping Cough	___	___	_____
Diphtheria	___	___	_____
Tetanus Basic	___	___	_____
Tetanus Booster	___	___	_____
Polio	___	___	_____

COMMUNICABLE DISEASES	YES	NO
Measles	___	___
German Measles	___	___
Scarlet Fever	___	___
Mumps	___	___
Chicken Pox	___	___

History of injuries: Please give a short account of all injuries. If none, please write none. _____

_____

_____

_____

_____

Form continued on the back.

History of operations: Please give a short account of all operations. If none, please write none. _____

_____

_____

_____

STUDENT MEDICAL HISTORY

Please check any that apply to this student.

____	Diabetes	____	High blood pressure	____	Rheumatic fever
____	Frequent head colds	____	Low blood pressure	____	Tuberculosis
____	Frequent chest colds	____	Epilepsy	____	Thyroid disease
____	Anemia	____	Arthritis	____	Sinus disease
____	Jaundice	____	Bladder disease	____	Kidney disease
____	Frequent tonsillitis	____	Heart disease	____	Fainting attacks
____	Frequent headaches	____	Diphtheria	____	Typhoid Fever
____	Allergies	____	Pleurisy	____	Malaria
____	Pneumonia	____	Asthma	____	Weight loss of over 10 lbs last year

FAMILY MEDICAL HISTORY

Please check any that apply to your family.

____	Allergy	____	Venereal disease	____	Mental disease
____	Brain tumors	____	Arthritis	____	Epilepsy
____	Cancer	____	Tuberculosis	____	High blood pressure
____	Leukemia	____	Kidney disease	____	Diabetes
		____	Heart disease		

Please list any medications taken regularly: _____

Please list any medication to which the student is allergic: _____

Has the student ever had psychiatric counsel? _____ yes _____ no If yes, please explain in a separate letter, including the circumstance and medication which was given.

Student's Height _____
Student's Weight _____

Please indicate if the student suffers from any of the following. If yes, please explain.

	YES	NO	EXPLANATION
Hearing Difficulty	____	____	_____
Speech Difficulty	____	____	_____
Sight Difficulty	____	____	_____
Dyslexia	____	____	_____

Does the student wear glasses? Yes __ No __ Please give the date of the last eye examination_____

Physician's Name _____ Phone _____

Address of Physician _____ City, Zip _____

Person completing form _____ Date _____

Relationship to student _____