Student Medical History

Date of Birth _______ /______ /_______ **Height** _________________ **Weight** ________________
Mo. Day Year

Please complete the information below.								
	YES	NO		YES	NO		YES	NO
Allergies			**Gastro-Intestinal**			**Heart Disorders**		
Asthma			**Frequent Headaches**			**Diabetes**		
Neurological Disorders			**Hearing Loss __L __R Hearing Aids**			**Vision Deficiency Wears contacts, glasses, patch**		
Frequent Ear Infections			**Learning Disability**			**Speech/Language Disorder**		
Urinary Tract Infections			**Muscle/Bone Weakness**			**Other (Explain)**		

If you checked yes to any condition listed here, please give directions for taking care of your child having these symptoms.

_____Yes ____No Is your child receiving medication and/or any kind of behavioral, medical, or psychological treatment at the present time?

If yes, what kind? ____

Will these medications be administered during school hours? _____Yes _____ No

List below anything special you wish to bring to our attention.

____

____

____

____________South Carolina Certificate of Immunization turned in.

Please Complete Both Sides Of This Form

Bob Jones Junior High Student Medical/Emergency Information

Student Name____ ____________________
Last **First** **Middle** **Nickname**

Address ____
Street/P.O. Box **City** **State** **Zip**

FATHER'S INFORMATION

Last Name		**First Name**	
Employer		**If you work for BJU, please put BJU Box or Dept. Mail Stop**	
Home Phone		**Work Phone and Extension**	
Cell Phone		**e-mail address**	

MOTHER'S INFORMATION

Last Name		**First Name**	
Employer		**If you work for BJU, please put BJU Box or Dept. Mail Stop**	
Home Phone		**Work Phone and Extension**	
Cell Phone		**e-mail address**	

Please indicate which is the preferred e-mail address for receiving student progress and grade information.

If your child is ill or has a medical emergency and we cannot reach you at the numbers listed above, please list below the person(s) we should call.

(1) Name ______________________________________ Phone Number___________________________

Relationship to Child ____

(2) Name ______________________________________ Phone Number___________________________________

Relationship to Child ____

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Physician's Name _________________________________ Phone Number _______________________________

Parent Signature __________________________________ Relationship to Child __________________________

Please return this form to the JH Office no later than Friday, August 21, 2009

Please Complete Both Sides Of This Form