

**BATESVILLE COMMUNITY SCHOOL CORPORATION
HEALTH HISTORY**



* Please return on or before the first day of school.

Name _____

Date of Birth _____

Address _____

Phone _____

Parent(s) _____

Weight _____ Height _____

Vision: Right 20 / _____ Left 20 / _____

Ears: Right 15 / _____ Left 15 / _____

B/P _____

IMMUNIZATION HISTORY (Mo./Day/Year)

DTaP 1) _____ 2) _____ 3) _____
Booster Dates 4) _____ 5) _____

Polio 1) _____ 2) _____ 3) _____
Booster Dates 4) _____

Hib 1) _____ 2) _____ 3) _____ 4) _____

HepB 1) _____ 2) _____ 3) _____

Varicella 1) _____ 2) _____
Chicken Pox disease (Date) _____

MMR 1) _____ 2) _____

Date: _____

Physician Signature _____ (Printed) _____

Address: _____

DENTAL EXAMINATION

Name of Child _____ Date _____

Comments or recommendations:

Examining Dentist _____ (Printed) _____

Address: _____