Health Form

Student Name: _____ Date of Birth: _____

Health History:	**Yes**	**No**	**Corrected:**
Visual Problems	____	____	_____
Heart Disorder	____	____	_____
Physical Disability	____	____	_____
Fainting Spells, epilepsy, Loss of consciousness	____	____	_____
Hearing Loss	____	____	_____
Nervous Disorders	____	____	_____
Other (please list)	____	____	_____
	____	____	_____

Special Needs/Concerns: _____

_____

Parent Signature: _____ Date: _____

Send back with application or bring the first day of class.