



Klamath Falls Adventist Christian School

2499 Main Street, Klamath Falls, OR 97601-2721
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STUDENT INFORMATION

Name: _____ Date of Birth: _____
Address: _____ Mother's Name: _____
City, State, Zip: _____ Father's Name: _____

PERSONAL HISTORY – (Please check illnesses/injuries the student has experienced.)

- | | | |
|-------------------------------------|--|--|
| <input type="radio"/> Cancer | <input type="radio"/> Measles | <input type="radio"/> Asthma |
| <input type="radio"/> Chicken Pox | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Hay Fever |
| <input type="radio"/> Diabetes | <input type="radio"/> Scarlet Fever | <input type="radio"/> Concussion/head injury |
| <input type="radio"/> Diphtheria | <input type="radio"/> Tuberculosis | <input type="radio"/> Muscle or joint pain |
| <input type="radio"/> Epilepsy | <input type="radio"/> Whooping Cough/Pertussis | <input type="radio"/> Other: _____ |
| <input type="radio"/> Heart Disease | <input type="radio"/> Frequent Ear Infection | _____ |

ALLERGIES – (Please list any known allergies.)

OTHER FACTORS – (Briefly explain any factors such as surgeries, serious accidents or injuries, congenital defects, speech defects, or vision problems which may affect the child's school experience.)

IMMUNIZATIONS – An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Accepted official records include:

- Oregon State Immunization Record
- Health provider record (with signature, stamp, or initials next to each date)
- Official immunization record from another state
- Oregon School Immunization Record (CSIR or "white card")

Parent's Release: I want my child to have the privilege of participating in school activities, including physical education classes, therefore he/she has my permission to compete in all sports, games and physical activities as part of the school program and/or as part of an after school program regulated by Klamath Falls Adventist Christian School. While I expect school authorities to exercise reasonable precautions to avoid injury, I understand that KFACS assumes no financial obligation for an injury that may occur. I authorize emergency medical treatment to be provided in case of injury or illness.

(Date)

(Signature of Parent or Guardian)