



9801 Arlington Church Road \* Mint Hill, NC 28227 \* 704-545-4589 \* [www.arlingtonacademy.org](http://www.arlingtonacademy.org)

## IMMUNIZATION RECORD

All students applying to Arlington Christian Academy must complete and submit this form with the application.

**Important Notice:** All K5 students accepted to ACA need to provide proof of a physical. The physical form must be completed by your doctor and turned into to the Admissions Office by the first day of school. The physical should be scheduled during the summer so that it will remain current for the student's entire kindergarten academic year. ACA will provide the physical form. Your K5 student will be unable to attend the first day of school without a completed physical form including updated immunizations on file.

**THIS PAGE IS NOT A PHYSICAL FORM.**

Name of Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_

Names of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**A. Medical History: (To be completed by the parent)**

a. Is your child allergic to anything? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what?

\_\_\_\_\_

b. Is your child under a doctor's care? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what for?

\_\_\_\_\_

c. Any previous hospitalizations or operations? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what for?

\_\_\_\_\_

d. Is your child on any continuous medication? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what for?

\_\_\_\_\_

\_\_\_\_\_

e. Does your child have any mental disabilities? \_\_\_\_\_yes \_\_\_\_\_No If yes, please describe:

\_\_\_\_\_

f. Does your child have any neurological or sensory disorders? \_\_\_\_\_Yes \_\_\_\_\_No  
If yes, please describe:

\_\_\_\_\_

g. Any history of diseases or recurrent illness? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what for?

\_\_\_\_\_

h. Does your child have any physical disabilities? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please describe:

\_\_\_\_\_

**B. Immunization Record: A health official must enter the date immunizations were received in the space below or attach a copy of the immunization record or submit a copy of the immunizations.**

Type of Vaccine:	#1	#2	#3	#4	\$5
*DPT or DT (Circle one)					
*Polio					
**Hib					
*MMR (Combined doses)					
***Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
***Hep. B (three doses)					
Varicella					
****Tdap					
Other					

**Required by State Law**

**\*\*Required by State Law if born on or after 10-1-1991.**

**\*\*\*Required by State Law if born on or after 7-1-1994.**

**\*\*\*\*If your child will turn 12 between August 2011 and July 2012, the state requires proof of Tdap immunization by September 30, 2011. Please have your physician's office fax proof of this immunization as soon as it is administered. Record of this immunization must be received no later than September 30, 2011.**

**Health Official's Signature/Title: \_\_\_\_\_**

**Date: \_\_\_\_\_ Phone: \_\_\_\_\_**

**Revised CAS 11/23/2024**