

CEDARS OF LEBANON ACADEMY

VITAL STATISTICS

Name of Student _____
(Last) (First) (Middle)

Date of Birth _____ Place of Birth _____

Certificate Number _____ Where Registered _____

Mother's Maiden Name _____

Physical defects or weakness:

Eyes _____ Glasses _____

Ears _____

Speech defects _____

Has student had:

Measles _____ Mumps _____ Chicken-pox _____

Whooping cough _____

Date of last vaccination _____ Certificate on file _____

Doctor to be notified in case of emergency _____

Remarks: _____

Referred by:

Family Member _____ Friend _____

Business Associate _____ Child Care Center _____

Other (list) _____