First Assembly Christian School
Child Health History Form
School Year__________

This form is to be completed by a parent/guardian and will enable the School Nurse to establish and maintain a comprehensive health history and health appraisal system. Information you provide will remain confidential and will only be shared on an as needed basis. Please provide accurate information so that your child will receive the best possible care.

Child's Name: ______________________ Birthdate: ______________
Homeroom Teacher (nurse to fill in):______________________ Grade:________Sex: M________F ________

Please note order to be called (i.e. 1st, 2nd, 3rd, etc):
Mother's Name: ______________ Father's Name: ______________
Mother's Home Phone Number: ______________ Father's Home Phone Number: ______________
Mother's Work Number ______________ Father's Work Number: ______________
Mother's Cell Number ______________ Father's Cell Number ______________

Emergency contact (please note relationship to child):
1. ______________________ Phone Number(s) ______________
2. ______________________ Phone Number(s) ______________

Please check all that apply to your child:

**Heart disease	Yes No	Diagnosis date:________	
**Diabetes	Yes No	Diagnosis date:________	
**Asthma	Yes No	Last episode: ________	
**Seizures	Yes No	Last seizure: ________	
**Cystic Fibrosis	Yes No		
**Sickle Cell Disease	Yes No	Last crisis: ________	
ADD/ADHD	Yes No	Medication: ________	
Kidney disease	Yes No	Type:________	
Hearing Problems	Yes No	Hearing aids:________	
Glasses	Yes No	Was eye exam within the past	
Contacts	Yes No	12 months? Yes No ______	

Chicken pox	Yes No	Date: ________
Frequent ear infections	Yes No	Tubes: ________
Frequent throat infections	Yes No	
Frequent headaches	Yes No	Type: ________
Stomach problems	Yes No	Type: ________
Menstrual Cramps	_____moderate_____severe	
Frequent nosebleeds	Yes No	
Significant injuries	Yes No	Date: ________
Specify:________________		
Major illness	Yes No	Date:________
Specify:________________		

Other illnesses or comments:______________________________

****My child is allergic to the following:**

Foods	Yes No	Specify: ________________
Latex	Yes No	Comments:________________
Penicillin	Yes No	Comments:________________
Tylenol	Yes No	Comments:________________
Motrin/Advil	Yes No	Comments:________________
Other	Yes No	Specify: ________________

****If you have checked any of the above items with an asterisk, the nurse will contact you for further information from you and/or your child's physician.**

My child is on the following daily and/or regular medications: ______________________

Physician's name: ______________ Office number: ______________
Dentist/Orthodontist:______________ Office number: ______________
Hospital preference:______________

I authorize the School Nurse to share the above health information as needed about my child with appropriate faculty/staff.

Parent/Guardian signature: ______________________Date: ______________

**Please use the back of this sheet to explain anything else we should know about your child's health development, behavior, family or home life that you would like to share with the school.

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