First Assembly Christian School
Child Health History and Information 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. Any 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 or circle all that apply to your child:

**Heart disease	Yes	No	Diagnosis date:_____	Chicken pox	Yes	No	Date: _____
**Diabetes	Yes	No	Diagnosis date:_____	Frequent ear infections	Yes	No	Tubes: _____
**Asthma	Yes	No	Last episode: _____	Frequent throat infections	Yes	No	
**Seizures	Yes	No	Last seizure: _____	Frequent headaches	Yes	No	Type: _____
**Cystic Fibrosis	Yes	No		Stomach problems	Yes	No	Type: _____
**Sickle Cell Disease	Yes	No	Last crisis:_____	Menstrual Cramps	_____moderate		_____severe
ADD/ADHD	Yes	No	Medication: _____	Frequent nosebleeds	Yes	No	
Kidney disease	Yes	No	Type:_____	Significant injuries	Yes	No	Date: _____
Hearing Problems	Yes	No	Hearing aids: _____	Specify:_____			
Glasses	Yes	No	Was eye exam within the past	Major illness	Yes	No	Date:_____
Contacts	Yes	No	12 months? Yes No _____	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:_____
Health Insurance Provider: _____ Policy number: _____
Insured's name: _____ Group number:_____
Insured's birthdate_____ Hospital preference: _____

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

Permission to treat: (please circle) Yes No

Parent/Guardian signature: _____ **Date:**_____

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

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