

First Assembly Christian School
Child Health History and Information Form
School Year _____ - _____

This form is to be completed you provide will remain confidential and will only by a parent/guardian and will enable the School Nurse to establish and maintain a comprehensive health history and health appraisal system. Information 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 we should know about your child's health development, behavior, family or home life that you would like to share with the school.**