Calvary Chapel Christian Academy

Student Health History

Name_____ **Date_____**

Grade/Section_____

1) Has your child ever had any serious illness? Y N

Please Explain_____

Has your child had the Chickenpox disease? Y N
At what age_____

2) Has your child had any operations? Y N
Please explain_____
_____

3) Is your child under the care of a doctor, clinic, or hospital now? Y N
Please explain_____
_____

4) Does your child have Asthma? Y N
What type? _____
Medications?_____

5) Has your child ever had a seizure? Y N
Please explain_____
_____

6) Does your child have Diabetes? Y N
How is it controlled? _____
_____

7) Does your child have heart disease/murmur? Y N
Is treatment or follow-up required? _____
_____

8) Does your child have problems with frequent ear infections or hearing? Y N

Please Explain_____
_____

9) Does your child have problems with vision? Y N
Please explain_____
_____

10) Does your child have allergies to: food Y N
medicine Y N
insect bites Y N
other? Y N
Please List _____
Are there treatments to be given, i.e. Benadryl, Epi-pen? Y N
_____

11) Is your child taking any medicines? Y N
Please list (include dose and time) _____
_____

Do medications need to be given in school? Y N
Please List _____
_____

12) Are there any conditions which might limit your child's activities in school? Y N
Please explain_____
_____

13) Does your child have any notable birthmarks or skin conditions? Y N
Please explain _____
_____

14) Please share any additional information that may be helpful in the care or your child.
_____
_____

Please keep the school nurse informed of any changes in your child's history, medications, etc. The above information will be shared only when deemed necessary for the well being of your child. If there is any information that you wish to remain strictly confidential, please explain on the back of this form.