

FIRST BAPTIST CHRISTIAN SCHOOL
School Health Information

GRADE _____ **TEACHER/HR** _____

STUDENT _____, _____ **M F** **DOB** _____ **STUDENT #** _____
Last Name First Name Circle

ADDRESS _____

HEALTH HISTORY (ANSWER YES OR NO)

ALLERGIES: (SPECIFY) _____

PHYSICAL HANDICAPS _____ DIABETES _____

ASTHMA _____ SEIZURE DISORDER _____

SICKLE CELL DISEASE _____ CANCER _____

OTHER PHYSICAL OR MENTAL HEALTH ISSUES WHICH MAY BE A CONCERN AT SCHOOL:

_____ Does your child require special seating in the classroom? Specify _____

_____ Does your child have any condition that would limit physical education activities? List _____

_____ Does your child take any prescribed medications routinely? List _____

_____ Did your child receive any immunizations this past year? List type, date _____

_____ Date of last tetanus shot? _____

EMERGENCY CONTACT INFORMATION

Father/Guardian _____ Phone(Home) _____ Pager _____
Name

Phone (Work) _____ Cellular _____

Mother/Guardian _____ Phone (Home) _____ Pager _____
Name

Phone (Work) _____ Cellular _____

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Child's Healthcare Provider _____ Phone _____

School clinic personnel have my permission to contact my child's physician for further medical information. In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child, _____.

Child's Name

Parent signature _____ Date _____