

DARREN PATTERSON CHRISTIAN ACADEMY



Returning Student Health Form

Dear Parents/Guardians of **returning students**,

Please fill out this health form on your student and return to the school to be kept as part of student's health file.

Student's name: _____
Student's birthdate: _____ Grade: _____ Sex: _____
Student's Doctor: _____ Phone: _____ Date of last exam: _____
Student's Dentist: _____ Phone: _____ Date of last exam: _____
Does your student wear glasses or contacts?

Please list any health problems your child has with a brief description. Are they receiving treatment? If so, what? Is it resolved?

If it is an old problem that presently affects student, please list and explain.

- | | |
|--|--|
| <input type="checkbox"/> Allergies? _____ | <input type="checkbox"/> Frequent infections? _____ |
| <input type="checkbox"/> Asthma? _____ | <input type="checkbox"/> Kidney disease? _____ |
| <input type="checkbox"/> Behavior/Emotional: <u>ADD,ADHD,OCD,etc</u> _____ | <input type="checkbox"/> Meningitis? _____ |
| _____ | |
| <input type="checkbox"/> Bleeding _____ | <input type="checkbox"/> Rheumatic Fever/Scarlet Fever? _____ |
| <input type="checkbox"/> Bone or joint problems _____ | <input type="checkbox"/> Seizures? _____ |
| <input type="checkbox"/> Chicken Pox disease _____ | <input type="checkbox"/> Stomach problems, ulcers? _____ |
| <input type="checkbox"/> Injury –recent? _____ | <input type="checkbox"/> Disabilities? Restrictions on activity? _____ |
| <input type="checkbox"/> Hearing/Ear problems? _____ | _____ |
| <input type="checkbox"/> Headaches/Migraines? _____ | <input type="checkbox"/> Hospitalizations/Surgery?(recent) _____ |
| <input type="checkbox"/> Heart problem? _____ | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

Brief Explanation: _____

Does your child need special attention at school related to a health problem?

Do any medications need to be taken at school? Yes _____ No _____
{If yes, please complete a Permission for Medication form (available at the school office) }
Please list medications and instructions:

****Permission to give your student non-aspirin or antacids: (please circle one) YES NO

Signature of Parent/Guardian **Date**