Grace Christian School
HEALTH RECORD

____ Gender: __Male __Female _____ / _____ / _____
Student's Last Name First Name Initial Birth Date

Father's Name: ______________________________ Mother's Name: ______________________________

____
Address City State Zip

Emergency Contact: ________________________________ ________________________________
Relationship Phone # Relationship Phone #

Physician's Name: ______________________________ Phone Number: ______________________________

Post Diseases – (If your child has had any of the following, state age when he/she had them.)

Mumps ________________
Measles ________________
Whooping Cough ________
Asthma ________________
Hay Fever ______________
Diphtheria ________________
Scarlet Fever ______________
Rheumatic Fever __________
Chicken Pox _______________
Pneumonia ________________
Polio __________________
Convulsions _____________
Heart Disease ____________
Diabetes ________________
Discharging Ears ________

Has your child had a skin test for tuberculosis? ____________________ Date administered ________________________
Has he/she been associated with a tubercular patient? _______________ When? ________________________________
Has your child been diagnosed with HIV/AIDS? __________________ When? ________________________________

Recent – (Please check any applicable items.)

Four or more colds yearly ______
Frequent sore throat __________
Poor Vision _________________
Frequent leg pains ____________
Dizziness ___________________
Frequent Sties _______________
Dental defects _______________
Fainting Spells ______________
Abdominal pains ___________
Frequent urination __________
Allergy ____________________
Persistent cough ____________
Speech difficulty ___________
Crippling conditions _________
Hearing difficulty __________
Tires easily _______________
Shortness of Breath _________
Hernia (rupture) ___________
Ring worm _______________
Nose bleeding _____________
Growing Pains ____________

Does your child have a disability due to disease or accident? ____

Is your child under physician care? ______________ specific diagnosis ____

What medications are currently being given to your child? ____
____

Are there any specific directions? ____
____

Please note any other important details:
____
____
____