Grace Christian School
HEALTH RECORD

_____ Sex: Male/Female _____ / _____ / _____
Student's Last Name First Name Initial Birth Date

Father's Name: _____ Mother's Name: _____

_____
Address City State Zip

Emergency Contact: _____ _____
Relation Phone # Relation 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:
_____
_____
_____