EMMANUEL
CHRISTIAN ACADEMY

Student Health History- 2017/2018

Student's Name: _____ D.O.B.: _____/_____/_____

Height: _____ Weight: _____ Grade: _____ Homeroom Teacher: _____

Parent/Guardian Name: _____ Name of Physician: _____

Past Medical History (check all that apply):

☐ **NO** Medical Conditions	☐ Diabetes: _____	☐ Seizure Disorder
☐ Asthma	☐ Depression	☐ Sickle Cell Anemia
☐ ADD/ADHD	☐ Ear Problems/Hearing Difficulties	☐ Skin Conditions: _____
☐ Arthritis: _____	☐ Emotional Concerns	☐ Speech Problems
☐ Autism	☐ Headaches	☐ Stool Soiling
☐ Behavioral Concerns	☐ Heart Disease: _____	☐ Traumatic Brain Injury
☐ Birth/Congenital Malformations	☐ Kidney Disease: _____	☐ Urinary Tract Infections
☐ Bone/Muscle/Joint Problems	☐ Lead Poisoning	☐ Vision Problems: _____
☐ Bleeding Disorder: _____	☐ Migraines	☐ Other: _____
☐ Cancer: _____	☐ Nervous Twitches/Tics	☐ Other: _____
☐ Chronic Diarrhea or Constipation	☐ Neuromuscular Disorder:	☐ Other: _____
☐ Cystic Fibrosis	_____	☐ Other: _____
☐ Daytime Wetting	☐ Seasonal Allergies	☐ Other: _____

Please explain any conditions above (if needed): _____

Please list any hospitalizations (reason & year): _____

_____

Allergies- (ECA cannot guarantee a food allergy free environment)

Allergy	Reaction
☐ Bee/Insect:	
☐ Food:	
☐ Medication:	
☐ Other:	
☐ Epi-Pen to be stored in clinic	

Medications- Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason
1.		
2.		
3.		
4.		
5.		

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain: _____

_____

_____

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain: _____

_____

_____

Please indicate any other information about your child's health or development that would be beneficial for the school to know.

_____

_____

_____

_____

_____

_____

_____

_____

Please contact the clinic nurse for a confidential conference if needed.

Completed by: _____ Relationship: _____ Date: ____/____/_____

Please note, if your child has a history of Asthma, Seizures, or a severe allergy to food and/or bee stings, an Emergency Action Plan needs to be completed. The forms may be printed off at ecaoh.com (under Resources, Forms) or you may stop by the clinic. A completed copy of the Emergency Action plan will be distributed to your child's teacher(s).