Health Information

Date_____Grade_____

Child's Name_____Date of Birth_____Sex_____

Local Physician's Name_____ Physician's Address_____ Physician's Telephone_____

Does Your Child Have:

Allergies	No	Yes	Specify_____
Asthma	No	Yes	Specify_____
Diabetes	No	Yes	Specify_____
Epilepsy/Seizures	No	Yes	Specify_____
Heart Condition	No	Yes	Specify_____
Orthopedic Problem	No	Yes	Specify_____
ADD/ADHD	No	Yes	Specify_____
Mental Health Con.	No	Yes	Specify_____

Has Your Child Had:

Serious Illness	No	Yes	Specify_____

Does Your Child:

Have trouble seeing close work	No	Yes	Seeing at a distance	No	Yes
Wear glasses	No	Yes	Wear contact lenses	No	Yes
Have trouble hearing	No	Yes	Wear a hearing aid	No	Yes
Have a condition which prevents Participating in regular P.E.	No	Yes	Specify_____		
Severe nose bleeds	No	Yes	Comments_____		

Has Your Child Had the Disease (State Approximate Age):

Chicken Pox	No	Yes	Rheumatic Fever	No	Yes
Measles (Hard)	No	Yes	Other_____		
Measles (3 Day)	No	Yes	Other_____		
Mumps	No	Yes			

MEDICAL HISTORY

1. Child currently has health problems: No Yes If yes, explain briefly:

_____

2 Child currently taking medication: No Yes If yes, list medicine(s):

_____

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care with the physicians or hospital of my choice.
If I cannot be reached to make the necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize Immanuel Lutheran School to provide medical care. In addition, I agree to the sharing of medical information with school faculty and staff on a need to know basis, including but not limited to medications, diagnosis, and physical restrictions or limitations.

_____ _____ _____

PRINT PARENT NAME PARENT SIGNATURE DATE