# Faith Christian School

Student Medical Information Form – Completed by Parent

Kindergarten　　4th-6th Grade　　9th-10th Grade

| Student's Name (Last, Middle, First) | | | Date of Birth |
|---|---|---|---|
| Address (Number, Street, City, State, Zip) | | | |
| Father | Phone | Preferred Hospital | |
| Mother | Phone | | |
| Physician | Physician's Office | | Phone # |

## Assessment of Student Health – To Be Completed by Parent

| | Yes | No | Comments |
|---|---|---|---|
| Allergies (Food, Insect, Medications, Latex) | | | |
| Allergies (Seasonal) | | | |
| Asthma or Breathing Problems | | | Personal Inhaler |
| Attention-Deficit/Hyperactivity Disorder | | | |
| Behavioral or Emotional Concerns | | | |
| Bleeding Problems | | | |
| Born Premature | | | How many weeks: |
| Concussions | | | |
| Dental Problems | | | |
| Developmental Delays | | | Mental　Physical |
| Diabetes | | | Has Insulin |
| Ear or Hearing Problems | | | |
| Eye or Vision Problems | | | Glasses　Contacts　Weak Eyes　Difficulty Reading　Squinting<br>Other Info: |
| Headaches | | | |
| Heart Problems or Concerns | | | |
| Heat Illness (Exercise Induced) | | | |
| Learning Concerns or Disabilities | | | |
| Loss of Function of One Paired Organ | | | Eye　Ear　Kidney　Other |
| MRSA | | | |
| Pneumonia (Regularly has had) | | | |
| Problem with Bladder | | | |
| Problem with Bowels | | | |
| Problem with Coughing | | | |
| Scoliosis/Spinal Problem | | | |
| Seizures | | | Prescribed Medication |
| Speech Problems | | | |
| Urinary Tract Infections (Regularly has had) | | | |

| Student Name: | Date of Birth: |
|---|---|

## Assessment of Student Health – To Be Completed by Parent

Dietary Needs/Restrictions:

Does your child take any daily medications? Yes No
If yes, names of medications: ___________________________________________________________________________________

Do they need the medications administered at school? Yes No
If yes, fill out attached student medication authorization form. **Office only**: form on file? Yes No

Are they prescribed any emergency medications? Yes No
If yes, fill out attached student medication authorization form. **Office only**: form on file? Yes No

Special Instructions/Devices: Helmet Safety Glasses Pacemaker Dental device Other:

Describe any other important concerns about your child whether they be academic, mental, physical, or health-related:

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the Faith Christian School and health care providers (student's physician or emergency personnel). I give the staff of Faith Christian School permission to authorize emergency medical treatment for my child in my absence.

| Printed name of parent/guardian: | Date: |
|---|---|
| Signature of parent/guardian: | |

# Faith Christian School – Physical Examination Form

To Be Completed by Health Care Provider

| Child's Name: | Date of Exam: |
|---|---|

| | Normal | Abnormal | Comments/Findings/Recommendations/Referrals |
|---|---|---|---|
| Height: ( ) inches | | | |
| Weight: ( ) pounds | | | |
| BMI: ( ) | | | |
| Pulse: ( ) | | | |
| Blood Pressure: ( / ) | | | |
| Skin | | | |
| Hair/Scalp | | | |
| Nose/Throat | | | |
| Mouth/Teeth | | | |
| Tonsils | | | |
| Heart | | | |
| Lungs | | | |
| Lymph Glands | | | |
| Abdomen | | | |
| Spine (Scoliosis) | | | |
| Posture | | | |
| Musculoskeletal | | | |
| Neurological | | | |
| Genito-Urinary | | | |
| Gastrointestinal | | | |
| Endocrine | | | |
| Eyes | | | Left Right Vision: ________/________<br>Comments: |
| Ears | | | Left Right Comments: |

Does the child have a diagnosed medical condition? Yes No

Specify if yes:

Does the child have a health condition which may require EMERGENCY ACTION while at school? Yes No

Describe if yes:

Is there anything else the school should know about this student?

Mental or Psychological Health:

Cognitive problems that may affect learning:

Additional Remarks by Physician:

On the basis of the examination, I approve this child's participation in:

Physical Activity in School Yes No
Modified:

Interscholastic Sports Yes No
Modified:

| Printed Name of Authorized Health Care Provider: | Signature of Authorized Health Care Provider: Date: |
|---|---|

# Faith Christian School
# Student Medication Authorization Form

No at-school medications needed　　　　Student may need medication(s) administered at school

| Student's Name | Date of Birth |
|---|---|
| Emergency Contact | |

| Medication: (other names) | |
|---|---|
| Prescribed for: Regular use<br>Emergency | How often/many times can it be administered? |
| Dosage: | Route of administration: |
| Counterindications: | |
| Intended effect: | |
| Expected side effects: | |
| Follow-up after administration: | Date for re-evaluation of prescription: |
| Physician's Printed Name | Date |
| Physicians Signature | |

| Medication: (other names) | |
|---|---|
| Prescribed for: Regular use<br>Emergency | How often/many times can it be administered? |
| Dosage: | Route of administration: |
| Counterindications: | |
| Intended effect: | |
| Expected side effects: | |
| Follow-up after administration: | Date for re-evaluation of prescription: |
| Physician's Printed Name | Date |
| Physicians Signature | |