HEALTH INFORMATION

Immunization information must be on file before a child can attend Providence Academy

Last Name_____ First Name _____
Grade _____ Date of Birth _____ Age _____

Past Health History

Please check if your student has ever had the following:

___ Arthritis
___ Asthma
___ Bleeding/Blood Disorder
___ Cancer
___ Chicken Pox
___ Diabetes
___ Emotional Concerns
___ Hearing Impairments
___ Heart Condition
___ Migraines
___ Scoliosis
___ Rheumatic Fever
___ Seizures
___ Vision Problems

Explain _____
_____
___ Other (Specify) _____
___ Serious Accident (Specify) _____
___ Surgery (Specify) _____
___ Allergies (Specify) _____
Please document your child's reaction to allergen (such as food or bee sting). Not necessary to document reaction for seasonal allergies. _____
_____
_____

Recent Health History

Please check if you have noticed any of these problems recently:

___ Poor Vision
___ Dizziness
___ Fainting Spells
___ Abdominal Pain
___ Persistent Cough
___ Speech Difficulties
___ Trouble Sleeping
___ Hard of Hearing
___ Tires Easily
___ Shortness of Breath
___ Ear Trouble (3/yr)
___ Strep Throat (3/yr)
___ Joint Pains
___ Bladder Problems
___ Bowel Problems
___ Bleeds Easily
___ Clumsiness

___ Other (Specify) _____
Please list any medications your child takes _____
_____

Parent's Signature _____ Date _____