



PROVIDENCE ACADEMY

®

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:

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emotional Concerns | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding/Blood Disorder | <input type="checkbox"/> Hearing Impairments | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Migraines | |

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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Joint Pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Tires Easily | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bleeds Easily |
| <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Ear Trouble (3/yr) | <input type="checkbox"/> Clumsiness |
| <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Strep Throat (3/yr) | |
| <input type="checkbox"/> Other (Specify) _____ | | |

Please list any medications your child takes _____

Parent's Signature _____ Date _____