HEALTH INFORMATION

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

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

Mother's Name_____ Cell Phone_____
Work Phone_____ Email_____

Father's Name_____ Cell Phone_____
Work Phone_____ Email_____

Emergency Contacts (not parents; must list two)

Name_____ Phone_____ Relationship_____
Name_____ Phone_____ Relationship_____

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 _____
_____

I hereby authorize Providence Academy Lower, Middle and Upper School to seek emergency care for my child. 9-1-1 will be the source of emergency care. Electronically signed an approved by:

Parent's Signature _____ Date _____

Form needs to be completed within 5 days of enrollment.
Return to Molly Kukuljan at molly.kukuljan@providenceacademy.org or by mail.