HORIZON
CHRISTIAN ACADEMY

Horizon Christian Academy Student Health Information

Name:_____ Grade:_____ Age:_____

Address:_____ Birthdate:_____

Mother Name & Phone:_____

Father Name & Phone:_____

Emergency Contact & Phone:_____

Allergies: Yes_____ (indicate below) No_____ (none known)

	Name/Type	Reaction	Treatment
Medications	_____	_____	_____
Environmental	_____	_____	_____
Foods	_____	_____	_____

Do we have your consent to administer over-the-counter medications if needed? YES_____

(Such as Tylenol, Neosporin, hydrocortisone cream, Tums, ect) NO_____

Medications/Supplements currently taking:

Name	Dose	Frequency	Med Indication

HEALTH HISTORY (Please check all conditions your child has had and explain below)

☐ ADD/ADHD ☐ Developmental delays ☐ Menstrual problems ☐ Skin problems
☐ Arthritis/joints ☐ Diabetes ☐ Mental health issues ☐ Stomach problems
☐ Asthma ☐ Hearing problems ☐ Migraines ☐ Surgeries
☐ Birth defects ☐ Heart problems ☐ Physical limitations ☐ Urinary problems
☐ Blood disorder ☐ Hepatitis ☐ Relationship issues ☐ Visual problems
☐ Bowel problems ☐ Hospitalizations ☐ Seizures, tics or tremors ☐ Other ☐ Cancer ☐ Learning problems ☐ Serious illnesses

Additional information/needs/concerns

_____

_____