STATEMENT OF HEALTH HISTORY

Student Name: ____ Age :_________ Grade Level: ___________________

Address: ____ Phone:_______________________

Is there any information we should have regarding the welfare of your child, such as handicaps, health restrictions, diets etc.?

☐ No ☐ Yes If yes, please explain: ____

____

Is there any activity you do not want your child to participate in?

☐ No ☐ Yes If yes, please explain: ____

____

What childhood diseases had your child had?

☐ Measles ☐ Polio ☐ Chicken Pox ☐ Scarlet Fever ☐ Other (Please explain)

____

____

Please check which Immunizations your child has received.

☐ Diphtheria Year ________ ☐ Whooping Cough Year ______ ☐ Tetanus Toxoid Year _______

Does your child have a history of any of the following physical conditions?

☐ Heart trouble ☐ Asthma ☐ Ear trouble ☐ Hernia ☐ Skin trouble ☐ Allergies ☐ Lung trouble

☐ Other (please explain)____

Are there any medications that your child is allergic to?

☐ No ☐ Yes If yes, please explain: ____

____

Does your child take any medications for allergies or medical conditions on a regular basis?

☐ No ☐ Yes If yes, please list the current medications your child is taking, and their purpose

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If your child has ANY changes in his/her medication history, please advise the school Administrator immediately.

Thank you for your time and call 904.722.1738 with questions. **Please send this completed form to:**
Seacoast Christian Academy, 8057 Arlington Expressway, Jacksonville, FL 32211, Attention: Director of Enrollment