



RAMAH CHRISTIAN ACADEMY

Student Health History

STUDENT INFORMATION

Student's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
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BIRTH AND DEVELOPMENT HISTORY

Did the mother have any unusual physical or emotional illness during this pregnancy? Yes No

Was infant born full term? Yes No Did the infant have any sickness or problems? Yes No

How does the child's development compare to other children? About the same Delayed Advanced

Please explain illness or problems.

DISEASE AND ILLNESS HISTORY

(Check (✓) any current or recurring condition.)

<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> autism <input type="checkbox"/> behavior concerns <input type="checkbox"/> birth/congenital malformations <input type="checkbox"/> bone/muscle/joint problems <input type="checkbox"/> blood problems <input type="checkbox"/> cancer <input type="checkbox"/> cerebral palsy <input type="checkbox"/> cystic fibrosis <input type="checkbox"/> depression <input type="checkbox"/> diabetes	<input type="checkbox"/> emotional concerns <input type="checkbox"/> frequent ear infections <input type="checkbox"/> frequent sore throats <input type="checkbox"/> headaches/migraines <input type="checkbox"/> hearing impairment <input type="checkbox"/> hearing aid <input type="checkbox"/> heart problems <input type="checkbox"/> hemophilia <input type="checkbox"/> HIV <input type="checkbox"/> juvenile arthritis <input type="checkbox"/> kidney disease <input type="checkbox"/> lead poisoning <input type="checkbox"/> neuromuscular disorder	<input type="checkbox"/> physical disability <input type="checkbox"/> wheelchair <input type="checkbox"/> respiratory ailment <input type="checkbox"/> scoliosis <input type="checkbox"/> seizure disorder <input type="checkbox"/> sickle cell anemia (not trait) <input type="checkbox"/> skin condition <input type="checkbox"/> speech problems <input type="checkbox"/> spina bifida <input type="checkbox"/> vision impairment <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> other _____ <input type="checkbox"/> other _____
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(Check (✓) as appropriate if your child has had any of the following.)

<input type="checkbox"/> injuries _____ <input type="checkbox"/> fractures _____ <input type="checkbox"/> measles <input type="checkbox"/> mental illness <input type="checkbox"/> mumps	<input type="checkbox"/> rubella <input type="checkbox"/> surgeries Type _____ Date _____ <input type="checkbox"/> tuberculosis	
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Please explain any checked (✓) health conditions or reasons for any hospitalizations.

ALLERGIES AND REACTIONS

Allergies	Reactions	Recommended Action
<input type="checkbox"/> Food:		
<input type="checkbox"/> Medicine:		
<input type="checkbox"/> Bee/Insect:		
<input type="checkbox"/> Other:		

MEDICATION TAKEN

Medication and Dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes No If yes, please explain:

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes No If yes, please explain:

ADDITIONAL COMMENTS OR HEALTH CONCERNS

PARENT / GUARDIAN INFORMATION

Signature	Relationship to Student	Date
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