#8 - Student Health Record

School: Lighthouse Christian Academy
Year: 2018-2019

Student Name: ______________________________
(*Please Print*)

Please Print All Information Legibly

Child's Name: ____

Address: ____

City: ________________________ State: ________ Zip: __________

Phone #: (______) ________—_____________ Phone Belongs to: ______________________

Family Physician: _____________________________ Phone #: (_____) ______—___________

Has your child ever been diagnosed or treated for any of the following illnesses or disorders:

Measles _____ Mumps _____ Chicken Pox _____ Flu _____

Meningitis _____ Diabetes _______ Epilepsy _____ Cancer _____

AIDS (or HIV Infection) _____ Whooping Cough _____

Eye, ear, nose or throat problems _____ Asthma _____ Hay Fever _____

Allergies _____ List any allergies ____

____

List any other medical disorders or problems: (*Use Separate Sheet if Necessary*)

(Continue On Back)

List **ALL** mediations that your child is on, and the purpose of the drug: (*Use Separate Sheet if Necessary*)

1. Medicine Name: ____

   Purpose: ____

2. Medicine Name: ____

   Purpose: ____

3. Medicine Name: ____

   Purpose: ____

4. Medicine Name: ____

   Purpose: ____

5. Medicine Name: ____

   Purpose: ____

I hereby declare the above health record for my child to be true and accurate to the best of my knowledge. By this form, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, or any other institution or person that has any information about my child's medical health, to give Lighthouse Christian Academy any such information (including information about AIDS or HIV infection). This form is valid for the entire time my child is enrolled at Lighthouse Christian Academy.

Signed: ______________________________ Relation to Child: ______________

Date: _____/_____/_____