Holy Family Classical Academy Medical Form

Name of student: _____ Date of Birth: _____

Name of Parent/guardian: _____ Cell phone: _____

_____ Work phone: _____

In case of emergency, contact parents
Emergency contact: _____ Phone: _____

Medical insurance: _____ Group/ID number: _____

Name of pediatrician: _____ Phone: _____

A. Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?
____ YES ____ NO If yes, please explain:

_____

_____

B. How does your child's development compare to other children, such as siblings or playmates?
____ About the same ___ Delayed ___ Advanced

C. Are your child's immunizations current?
_____ YES (please provide immunization record) _____ NO (please provide exemption)

D. Student medical history:

____ YES, My child receives regular medical care for the following conditions:

_ asthma _ allergies _ ADD/ADHD _ autism _ behavior concerns _ birth/congenital issues _ bone/muscle/ joint issues _ blood problems _ bowel/bladder problems _ cancer _ cystic fibrosis	_ diabetes _ depression _ ear problem/hearing issue _ emotional concerns _ headaches _ heart problems _ hemophilia _ juvenile arthritis _ lead poisoning _ migraines _ neuromuscular disorder	_ seizure disorder _ sickle cell anemia _ skin conditions _ speech problems _ developmental delay _ traumatic brain injury _ vision problems _ nosebleeds _ high blood pressure _ motion sickness	_ other_____ _ other_____ _ other_____ _ other_____ _ other_____

____ **NO,** my child has no medical conditions

Please explain any conditions above or any reasons for hospitalizations:

_____

_____

E. Medications:

Please note that we do not currently have a school nurse and if medications are to be given during the day, they will need to be administered by a parent/guardian.

Name and dosage of medication: _____ Used for: _____

Name and dosage of medication: _____ Used for: _____

F. Please indicate any allergies your child may have

Allergy type	Reaction	Restrictions or recommended actions
___ Bee/insect:		
___ Food:		
___ Medication:		
___ Other:		

G. Please indicate any other information about your child's health or development that you think would be helpful for the school to know

_____

_____

_____

Form completed by: _____ Relationship to student: _____

Date: _____