

School Health Record

La Palma Christian School
8082 Walker St. - La Palma - CA 90623

Name: _____
Last First

M F Birthdate: _____

Birthplace: _____

Parent/Guardian: _____

Address: _____

Cell/Home #: _____ Work #: _____

Examinations

When was your child's last physical exam? _____

Any problems noted? _____

Has your child ever had a vision exam? Yes No

When _____ Glasses prescribed? Yes No

Has your child been seen by the dentist? Yes No

When _____ Any problems? _____

Please describe any surgeries: _____

Any serious accidents/injuries: Yes No Please describe: _____

Was your child born premature? Yes No

Any problems at birth? _____

Medical History

Bee sting sensitivity? Yes No Mild Severe

Allergies (asthma, hay fever, eczema) _____

Diabetes Seizure Heart Condition Fainting Tuberculosis

Orthopedic Problem Urinary Problem

If any boxes are checked, please explain: _____

Receives regular medication? Yes No

Name(s) of medication: _____

When is medication given? _____

Does child have any hearing loss? Yes No

Does child have frequent ear infections? Yes No

Any physical restrictions? (Before a student may be excused from physical education, a doctor's statement indicating the specific limitation must be submitted): _____

Special health problem(s): _____

Special education: _____

Parent/Guardian Signature _____

Date _____