Sonshine Christian Academy

Student Medical Records Packet

THE FOLLOWING QUESTIONNAIRE IS TO BE COMPLETED BY THE PARENT / GUARDIAN:

Student's Name _____ Gender _____ Date of Birth _____

Mother's Name _____ Father's Name _____

Guardian's Name(s) _____

4. Did the mother have any unusual problems or illness during the pregnancy or delivery? ☐ Yes ☐ No
   If "Yes", explain briefly: _____
   _____
2. Was the baby born full-term? ☐ Early ☐ Full-Term ☐ Late
3. How much did the baby weigh at birth? _____lbs. _____oz.
4. Did the baby have any sickness or problems while in the hospital, such as yellow jaundice, blue spells or convulsions? ☐ Yes ☐ No
   If "Yes", explain briefly: _____
   _____
1. Please give the approximate age at which the child did the following:
   Sat up alone _____ Walked _____ Was toilet trained _____
   Said single words _____ Spoke in sentences _____
2. How does the child's development compare to other children, such as brothers, sisters or playmates?
   ☐ About the Same ☐ Slower ☐ Faster
3. Please indicate any **HEALTH CONDITIONS** this child has had by checking any of the following boxes that apply:

☐ Chicken Pox (If yes, what year? _____)
☐ Diabetes
☐ Eye problems, poor vision or crossed eyes
☐ Frequent ear infections
☐ Tubes in ears
☐ Frequent headaches
☐ Frequent nosebleeds
☐ Frequent sore throats
☐ High fevers
☐ Poor hearing
☐ Seizures of epilepsy
☐ Sickle cell disease
☐ Toothaches / dental infections
☐ Other-Please list: _____
_____
_____

8. Is your child sick often? ☐ Yes ☐ No
   If "Yes", explain briefly: _____
   _____

Please list and describe **ALLERGIES OR REACTIONS** to any of the following:

MEDICINES/DRUGS:

_____	_____	☐ Yes ☐ No
(Medicine / Drug)	(Recommended treatment for reaction)	(Allergy Shots)
_____	_____	☐ Yes ☐ No
(Medicine / Drug)	(Recommended treatment for reaction)	(Allergy Shots)

FOODS/PLANTS/OTHER:

_____	_____	☐ Yes ☐ No
(Food / Plant / Other)	(Recommended treatment for reaction)	(Allergy Shots)
_____	_____	☐ Yes ☐ No
(Food / Plant / Other)	(Recommended treatment for reaction)	(Allergy Shots)

BEE OR WASP STINGS:

_____	_____	☐ Yes ☐ No
(Bee or Wasp Stings)	(Recommended treatment for reaction)	(Allergy Shots)

10. Does the child have **ASTHMA** that has been diagnosed by a doctor? ☐ Yes ☐ No

    If "Yes", what treatment has been prescribed? _____

    _____

11. Please list any severe **INJURIES, ILLNESSES OR SURGERIES:**

Injuries, Illnesses, Surgeries	Age of child at time of occurrence	Hospitalized for this occurrence?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

What medications are given to the child daily? _____

What medications are given to the child frequently, but not daily? _____

This child is usually: ☐ Very Active ☐ Normally Active ☐ Rather Inactive

Do any family members have long-term illnesses such as diabetes or high blood pressure? ☐ Yes ☐ No

If "Yes", what illnesses? _____

16. Do you have any other comments or concerns about this child's health, development, behavior, family or home life of which you would like for the school to be aware? ☐ Yes ☐ No

    If "Yes", please explain: _____

SIGNATURE OF PARENT/GUARDIAN COMPLETING THIS FORM: _____ **DATE** _____

FOR KINDERGARTEN STUDENTS ONLY (TO BE COMPLETED BY THE PARENT/GUARDIAN)

1. Has your child attended pre-school? ☐ Yes ☐ No
2. Number of days per week? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
3. Relating to your Child's Development, please check the boxes below which best describe your child:

	Self	**Help**
Uses a spoon	☐	☐
Washes & dries hands	☐	☐
Dresses self	☐	☐
Buttons clothing	☐	☐
Toilet trained during day	☐	☐
Toilet trained during night	☐	☐

Fine Motor	**Yes**	**No**
Plays successfully with puzzles and blocks	☐	☐
Holds pencil properly	☐	☐
Prefers Left Hand	☐	☐
Prefers Right Hand	☐	☐
Prefers Both Hands	☐	☐

Social	**Yes**	**No**
Highly active	☐	☐
Very quiet	☐	☐
Often has temper tantrums	☐	☐
Has a very short attention span	☐	☐
Seems unhappy a great deal of the time	☐	☐
Cries & fusses when left with babysitter	☐	☐
Sleeps too much, too little, or poorly	☐	☐

Language	**Yes**	**No**
Began speaking later than other children you know	☐	☐
Stutters often and repeats sounds or words	☐	☐
Uses immature speech	☐	☐
Speaks mainly in 2-3 word phrases	☐	☐
Afraid to speak	☐	☐
Has trouble following directions	☐	☐

SIGNATURE OF PARENT/GUARDIAN COMPLETING THIS FORM: _____ **DATE** _____

MEDICAL RECORD (TO BE COMPLETED BY THE CHILD'S HEALTH CARE PROVIDER)

NOTE: This form MUST be completed and submitted to SCA Office before your student can start. *All children entering school are* ***REQUIRED*** *to have medical and dental examinations. This information is confidential and becomes a part of the student's cumulative record.*

Child's Name _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Gender _____ Grade Entering _____

HEALTH SCREENING

Height _____ Visual Activity: Right _____ Left _____

Weight _____ Hearing Activity: Right _____ Left _____

Strabismus: _____ Color Vision: _____

IMMUNIZATION REQUIREMENTS

Section 3313.671 of the Ohio Revised Code requires children of school age to be immunized against diphtheria, whooping cough, tetanus, polio, rubella, mumps and Hepatitis B. Please provide the appropriate date for the information listed in the chart.

DtaP, DPT, DT					
Polio					
MMR					
Hepatitis B					
Varicella					
Hib					
TB Test		Results			
Other					

PHYSICAL EXAMINATION

Surgical History: _____

Medical History: _____

Perinatal History: _____

Allergies: _____

Medications: _____

Head & Neck: _____

BP: _____

Orthopedic: _____

Chest: _____ Heart: _____

Lungs: _____ Abdomen: _____

Hernia: _____ Extremities: _____

Neurological: _____

Behavioral/Emotional: _____

_____

OTHER RECOMMENDATIONS AND COMMENTS: _____

SIGNATURE OF HEALTH CARE PROVIDER: _____ **DATE** _____

PROVIDER PRINTED NAME OR STAMP: _____ **PHONE** _____

DENTAL RECORD (TO BE COMPLETED BY THE CHILD'S DENTIST)

Please note that this form MUST be completed and submitted to SCA Office before your student can start. *All children entering school are* ***REQUIRED*** *to have medical and dental examinations. This information is confidential and becomes a part of the student's cumulative record.*

Child's Name _____

Street Address _____

Date of Birth _____ Gender _____ Grade Entering _____

Child was examined by _____ on _____
(Dentist Name) (Date)

The following services have been performed: (Please Check All That Apply.)

☐ Radiographs

☐ Oral Prophylaxis

☐ Fluoride Treatment

☐ Restorations

The following statements are applicable: (Please Check All That Apply.)

☐ All necessary services have been performed

☐ No restorative services are required at this time

☐ The child is in treatment and future appointments have been arranged

SIGNATURE OF DENTAL CARE PROVIDER: _____ **DATE** _____

PROVIDER PRINTED NAME OR STAMP: _____ **PHONE** _____