Sonshine Christian Academy

Medical Records Form

Student Name: _____

Date of Birth: _____ Male/Female: _____ Parent/Guardian Phone Number: _____

Please meet with the school nurse if the student has health needs.			
Check yes or no, if yes—please complete the section related to the response.			
TB	Was the student born OUTSIDE of the US? If Yes, in what country?	□YES	□NO
	Has the student been in the US for ≥5 years?	□YES	□NO
	Has the student traveled outside of the US for ≥ 60 consecutive days? If yes, to what country?	□YES	□NO
Development	Any health problems during pregnancy or birth of this child? Birth weight? _____	□YES	□NO
	Was the child born premature (early)? How many weeks? _____ Newborn health problems: _____	□YES	□NO
	Does this child have development delays? Current problems with: □Sitting Up □Walking □Toilet training □Speaking □Other Problems or concerns: _____	□YES	□NO
Allergies	Medicine Allergy _____ Describe reaction: _____	□YES	□NO
	Food Allergy _____ Describe reaction: _____	□YES	□NO
	Bee/Wasp Allergy _____ Describe reaction: _____	□YES	□NO
	Other Allergy _____ Describe reaction: _____	□YES	□NO
	Will this child need an **EPI-PEN** or other allergy medicine at school?	□YES	□NO
Health Conditions	Check ALL that apply to this child: □Asthma □Behavior Concerns □Hearing Problems: _____ □ADHD/ADD □Seizures or epilepsy □Tubes in ears □Hearing device □Diabetes □Heart problems □Vision Problems: _____ □Headaches □Sickle Cell: □disease / □trait □Learning difficulties, describe: _____ □Mental health concerns, depression, anxiety: _____ □Other: _____	□YES	□NO
Meds	Does this child take medications at home every day? (Please list the medications at the bottom of the form)	□YES	□NO
	Will this child need medications at school?	□YES	□NO
Health History	Has this child ever had Chickenpox? □YES—Date: _____	□YES	□NO
	Has this child ever had surgery? Explain: _____	□YES	□NO
	Has this child been to the hospital or gone unconscious after a head injury or concussion?	□YES	□NO
	Does this child need a special diet? If yes, what kind? _____	□YES	□NO
	Does this child use glasses, hearing aids, walker, leg braces, wheelchair, catheter, feeding tube, or other adaptive devices? (Please circle which ones)	□YES	□NO
Please add details from above: Medications, other concerns about the child's health, development, behavior, family, or home life here:			

Completed by: _____ Relationship to Student: _____ Date: _____