EMMANUEL
CHRISTIAN ACADEMY

Student Health History 2023/2024

Student's Name: _____ D.O.B.: _____/_____/_____

Height: _____ Weight: _____ Grade: _____ Homeroom Teacher: _____

Parent/Guardian Name: _____ Name of Physician: _____

Past Medical History (check all that apply):

- ☐ **NO** Medical Conditions
- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Arthritis: _____
- ☐ Autism
- ☐ Behavioral Concerns
- ☐ Birth/Congenital Malformations
- ☐ Bone/Muscle/Joint Problems
- ☐ Bleeding Disorder: _____
- ☐ Cancer: _____
- ☐ Chronic Diarrhea or Constipation
- ☐ Cystic Fibrosis
- ☐ Daytime Wetting
- ☐ Diabetes: _____
- ☐ Depression
- ☐ Ear Problems/Hearing Difficulties
- ☐ Emotional Concerns
- ☐ Headaches
- ☐ Heart Disease: _____
- ☐ Kidney Disease: _____
- ☐ Lead Poisoning
- ☐ Migraines
- ☐ Nervous Twitches/Tics
- ☐ Neuromuscular Disorder: _____
- ☐ Seasonal Allergies
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Skin Conditions: _____
- ☐ Speech Problems
- ☐ Stool Soiling
- ☐ Traumatic Brain Injury
- ☐ Urinary Tract Infections
- ☐ Vision Problems: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Please explain any conditions above (if needed): _____

Please list any hospitalizations (reason & year): _____

_____

Allergies- (ECA cannot guarantee a food allergy free environment)

☐ No Known Allergies

Allergy	Reaction
☐ Bee/Insect:	
☐ Food:	
☐ Medication:	
☐ Other:	
☐ Epi-Pen to be stored in clinic	

Medications- Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason
1.		
2.		
3.		
4.		
5.		

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain: _____

_____

_____

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain: _____

_____

_____

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

_____

_____

_____

_____

_____

_____

_____

Please contact the clinic nurse for a confidential conference if needed.

Completed by: _____ Relationship: _____ Date: ____/____/_____

*Please note, if your child has a history of Asthma, Seizures, or a severe allergy to food and/or bee stings, an Emergency Action Plan needs to be completed. The forms may be printed off at ecaoh.com (under Resources, Forms) or you may stop by the clinic. A completed copy of the Emergency Action plan will be distributed to your child's teacher(s).