

**Salisbury Adventist School  
Health Information Form**

2003/04  
School Year

Student's Name: \_\_\_\_\_ Home Number: \_\_\_\_\_

Mother's/Guardian's Name: \_\_\_\_\_  
Work Number: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Father's/Guardian's Name: \_\_\_\_\_  
Work Number: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

- ◆ Please list any medical, dental, behavioral, educational, or physical needs to be considered during the school hours:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- ◆ List any allergies your child has (e.g. food, insect stings, medicines, pollens, etc.)

\_\_\_\_\_  
\_\_\_\_\_

- ◆ Does your child have any vision problems? \_\_\_\_\_ Date of last exam: \_\_\_\_\_
- ◆ Do they have and need to wear glasses? \_\_\_\_yes \_\_\_\_no During PE? \_\_\_\_\_

- ◆ List any condition in which your child is currently receiving medical care :

\_\_\_\_\_  
\_\_\_\_\_

- ◆ Date of last check up: \_\_\_\_\_

- ◆ Does your child take medication on a regular basis? \_\_\_\_yes \_\_\_\_no  
If yes, list medication and possible side effects. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- ◆ Does your child need to take medication during school hours? \_\_\_\_yes \_\_\_\_no  
Please fill out medication form, if answer is yes.

- ◆ Does your child suffer from any current emotional stresses? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

- ◆ Briefly describe your pregnancy with this child. Did your child experience birth trauma?

\_\_\_\_\_  
\_\_\_\_\_

- ◆ At what approximate age did your child reach the following developmental milestones:  
crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_ toilet trained \_\_\_\_\_

◆ **Please check any of the following illnesses or behavioral difficulties your child has or has had:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Hearing problems   |
| <input type="checkbox"/> Bleeding problems     | <input type="checkbox"/> Cerebral Palsy  | <input type="checkbox"/> Meningitis         |
| <input type="checkbox"/> Bone/Muscles problems | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bowel problems        | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Skin problems      |
| <input type="checkbox"/> Cancer/Leukemia       | <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> Speech problems    |
| <input type="checkbox"/> Convulsions/Seizures  | <input type="checkbox"/> Heart problems  | <input type="checkbox"/> Stomach aches      |
| <input type="checkbox"/> Sore throats          | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Leg cramps         |

Other: \_\_\_\_\_  
\_\_\_\_\_

◆ **Please sign and update the form as necessary since new conditions may occur during the school term.**

\_\_\_\_\_  
(parent's signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(date)