AMBASSADOR CHRISTIAN ACADEMY

MEDICAL HISTORY

To be completed by parent/guardian

NAME: ____ DATE: _________________

1. Is your child currently under a physician's care? _________

2. Is your child taking medication(s)? If yes, please list:

   ____

   ____

3. Does your child have any allergies (food, medications, bee stings or other)? If yes, please list:

   ____

   ____

4. Does your child wear glasses? _______ contacts? _______

5. Please check if your child has had or has any of the following:

nose bleeds	_______	fainting	_______
chicken pox	_______	dizziness	_______
rheumatic fever	_______	heart condition	_______
ear infections	_______	thyroid condition	_______
seizures	_______	kidney condition	_______
asthma	_______	orthopedic problem	_______
diabetes	_______	hearing problem	_______
bleeding disorder	_______	mental disorder	_______

6. Are there any medical reasons or implications for limited physical or educational activity during the school day?

____

____

7. My signature below authorizes the school nurse to share information with appropriate staff only when it is necessary to insure the health and welfare of my child.

____ ____________________

SIGNATURE OF PARENT/GUARDIAN DATE