Dr. D.D. Brown Christian Academy of Hope

STUDENT HEALTH APPRAISAL FORM

Name: _____
Last First Middle

Address: _____
Street City State Zip

Birthdate: _____ Male _____ Female _____
Month Date Year

Does your child wear glasses? Yes/No Contacts? Yes/No

Name of Child's Doctor: _____

Address: _____

Phone Number: _____

Health Insurance Information:

Name of Company _____

Address _____

Contact Number _____ Policy/Member # _____

Has your child ever had an allergic reaction to anything (eggs, peanut butter, bee stings, etc)? If yes, please give the date and severity of the reaction.

_____

_____

Has your child ever been on special medication? If yes, please give the medication and the reason for the medication.

Is your child permanently taking regular medication? If yes, please give name of medication and reason for medication.

Dr. D.D. Brown Christian Academy of Hope

Has your child ever had a serious injury we should be made aware of? If yes, please give details of the injury.

_____

_____

Is there any other medical information not listed that Dr. D.D. Brown Christian Academy of Hope should be made aware of?

_____

_____

Place an 'X' if child has problems with any of the following:

___ Allergies ___ Epilepsy/Seizures ___ Asthma ___ Hearing

___ Speech ___ Constipation/Diarrhea ___ Frequent Colds ___ Vision

___ Fainting ___ Behavior Problems ___ Physical Handicap ___ Breathing

Please provide details:

_____

_____

_____ _____

Parent Signature Date

_____ _____

Parent Signature Date