Shining Starr Learning Academy Health History

First Name	**Last Name**	Middle Name	Date of Birth
Street Address	City, State, Zip	Who student lives with	Age Gender

In case of an emergency list 3 contacts in order of who is the most available:

First Name	Last Name	Relationship	Cell Phone #

Check any if applicable:		**ALLERGIES**
Bleeding Disorders	Anxiety	Asthma
Chicken Pox	Asperger Syndrome	Hay Fever
Diabetes	Austism Spectrum	Plants/Pollen Allergy
German Measles	Developmental Delay	Medication
Heart Disease	Dyslexia	Insect Bites/Stings - which ones/ reaction
Kidney	Ear Infections	
Lyme	Hearing Loss	**Food** - if so what specifically?
Measles	Menstrual - started	
Mumps	OCD	
Rheumatic Fever	Vision	**Animals** - if so which ones?
Seizures	Occupational Therapy	
Tuberculosis	Speech Therapy	
Other		**Currently taking - medicine/vitamins**
	Sensory - which ones?	
Any major surgeries		

This health history is complete to the best of my knowledge at the time of enrollment. If at any time there is a health change, I will notify the school and update the current form.

Print Parent Name Signature of Parent Date Signed