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 contacts in order of who is the **most available**:

First Name	Last Name	Relationship	Cell Phone #

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

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