MEDICAL HISTORY 2026-2027

(PLEASE PRINT)

Full Legal Name	Nickname

Student's name:______________________________ (____________)

Birthdate:__________ Grade entering__________ Gender (circle one): Male Female

Child's physician:______________________________ Physician phone:__________

Physician's address:______________________________

Check any of the following conditions your child has or has had and explain in detail below any current or long-term **TREATMENTS/MEDICATIONS /EDUCATIONAL ADJUSTMENTS:** *(If additional space is needed, please attach a separate sheet to this form.)*

___ Blood disorder (anemia, etc.)
___ Emotional problems (depression, anxiety, etc.)
___ Seizure disorder (epilepsy, etc.)
___ Learning difference (ADD, etc.)
___ Ear problem (deafness, mastoiditis, etc.)
___ Liver disorder
___ Kidney stones or disease
___ Tuberculosis
___ Frequent infections
___ Migraines
___ Endocrine disorder (diabetes, hypoglycemia, etc.)
___ Surgeries
___ HIV or AIDS
___ Heart problems
___ Rheumatic fever
___ Vertigo/fainting spells
___ Sinus problem

EXPLANATION:______________________________

____

Any limitations/activities your child should not engage in? Please explain:______________________________

____

Any social or family situations/problems of which the school should be aware?______________________________

____

Long-Term Medications to Be Administered **At School**

****NOTICE: Due to our school not having a registered nurse on staff, there will be NO long term medications administered at school by school staff. If your child is on long-term medication, someone designated by a parent/guardian may come administer daily.****

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Long-Term Medications Taken **At Home** (allergy, ADD, anxiety, asthma etc.)

Medication	Medical Condition	Dosage/Frequency

Allergies **(Please specify what the child is allergic to, symptoms, and treatment.)**

Medications:____

Foods:____

Other:____

Respiratory Problems **(Please explain current treatments/medications)**

Asthma:________________________ Reactive Airway Disease:____________________________

Other:____

Will your child be carrying an inhaler? Yes No

(If Yes, a signed Physician's Request for Self-administration of Medication <u>by Student</u> MUST be on file.)

Will an inhaler be available in the First Aid Station? Yes No

I hereby certify that to the best of my knowledge, the information supplied herein concerning my child's physical and emotional health is accurate and complete, and I agree to keep FBC Warren Christian School apprised of any changes to this information that may occur during the course of this school year. I understand that the school will not be held responsible for anything that may happen as a result of false information given at the time of enrollment.

Should my child suffer an injury or illness while in the care of FBC Warren Christian School, and the staff are unable to contact me immediately, the school personnel shall be authorized to secure such medical attention and care for the child as may be necessary. I shall assume the responsibility for payment of services. I understand that the insurance carried by the school is secondary coverage.

I hereby grant permission to the staff to take whatever steps may be necessary to obtain emergency medical care, if warranted. These steps include, but are not limited to the following:

- **Attempt to contact a parent/guardian.**
- **Attempt to contact the child's physician.**
- **Attempt to contact you through any of the persons listed on the enrollment packet.**

If we cannot contact you, or your child's physician, we will do any or all of the following:

- **Call another physician.**
- **Call for an ambulance.**
- **Have the child taken to <u>BRADLEY COUNTY MEDICAL CENTER EMERGENCY ROOM</u> in the company of a staff member.**

The school staff agrees to keep me informed of any incidents requiring professional medical attention involving my child.

SIGNATURE____ **DATE**______________

Parent or Legal Guardian

☐ Please attach a ***complete and validated*** immunization record. ☐

All submitted immunization documents **MUST** show the ***complete*** day, month, and year each immunization was received.