

HEALTH HISTORY SCREENING

LUTHERAN CHURCH AND SCHOOL OF MESSIAH

Child's Name _____

Grade _____ Birthdate _____ Male Female

The following information is considered confidential and is for the use of teachers, principal, or other staff who will be in contact with and responsible for your child during the school day.

Current Medical Care and Health

Child's Local Physician _____ Phone # _____

Date of Last Health Check _____ How is your child's health? Good Fair Poor

Does your child have a medical diagnosis? Yes No

Explain _____

Any long term and/or chronic illness? Yes No

Describe _____

How many days a year does your child usually miss school? _____

Usual Reason _____

Any physical limitations and/or adaptive equipment? Yes No

Explain _____

If taking medication regularly, please give name of medication and purpose _____

Past Medical History and Illness (Please check those that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hernia | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Red Measles (10 Day) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Bone/Joint | <input type="checkbox"/> Mumps | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Sore Throats | <input type="checkbox"/> Problems | <input type="checkbox"/> Rubella (3 day) | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> High Blood Pressure | | |

Allergies (please describe) _____

Asthma (please describe attacks per year, name of medication) _____

Other illnesses, surgeries, hospitalization (describe) _____

Date _____ Parent/Guardian _____

Relationship to Student _____ Parent/Guardian Phone (Home) _____

(Work) _____

MEDICATION PERMISSION FORM

I, _____, give
permission for Messiah Lutheran School office personnel to give my child,
_____, the following medication with
these instructions:

Parent/Guardian _____

Relationship to Child _____

Date _____
