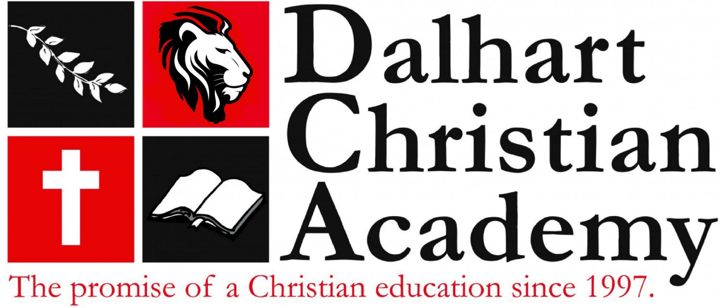

Dalhart Christian Academy
Confidential Health Form

Dear Parent/Guardian:
The information that is requested on this form is needed to maintain a school health record for your child. Please understand that this information may be shared with school or emergency personnel who have a need to know.

Child's First Name **Middle** **Legal Last Name**
Nickname

( ) Male ( ) Female Date of Birth________________ Grade___________

Mother's Name _________________________________ Mother's Primary Phone______________________________
Other form of emergency contact ____________________________

Father's Name__________________________________ Father's Primary Phone_______________________________
Other form of emergency contact ____________________________

( ) My child has no known life threatening allergies at this time. Please check any life-threatening allergies to anything listed below.
***Action plan is needed from the doctor for all of the following:**
Asthma, life-threatening allergies, diabetes, seizures, heart conditions.

Medication:___________________________________ What happens?____
Food:____ What happens?____
Other:____ What happens?____

During the past year, has your child been hospitalized? ( ) No ( ) Yes, please explain______________________________________

Please indicate if your child has any of the following health problems: **( ) No Known Health Problems**

Yes	Health Problem	Age	Treatment/Medications/History	Action Plan Required
	Asthma			
	Seizure/Neurological			
	Diabetes			
	Heart Problems/ BP			
	ADD/ADHD			
	Arthritis			
	Bone/Joint Problems			
	Bladder Problems			
	Bleeding Disorders			
	Hearing Problems		Hearing Aids: Yes No	
	Mental Disorders			
	Scoliosis-spine curvature			
	Sleep Problems/Nightmares			
	Skin Disorders			
	Sinus / Seasonal Allergies			
	Vision Problems		Glasses: Yes No Contacts: Yes No	

Medications to be taken at school: ( ) No ( ) Yes ****If yes, please fill out the medication form.**

Please note: The school nurse or any other school personnel may not give any medication without written permission from a parent or legal guardian. Any daily medication, which needs to be given for longer than one month, must have written permission from a physician. All medication must be in the original container with a proper label. Prescription medication must contain the physician's name; child's name, current date, correct dosage and directions for use. In addition, the child's medication plan must be such that the medication cannot be sufficiently administered outside of school hours.

We grant permission for the school officials to act in lieu of us, should an injury to my child, in securing emergency medical services if they appear to be needed. I also agree unless otherwise noted in writing that this health information may be shared with others related to the care and safety of my child and I give my permission for Dalhart Christian Academy's administration to receive healthcare information from my child's physician or other healthcare provider(s).

Parent/Guardian signature ____
Date _________________

<u>Action Plan Acknowledgment</u>**

I acknowledge that I am responsible for providing all information about my child's health and understand that I am required to fill out an Action Plan for the above listed medical conditions. I understand that a Dr.'s note is required at the beginning of the school year and that my child will not be able to attend school until I have submitted a signed Action Plan with a Dr.'s note to the office.

Parent/Guardian signature ____
Date _________________