ALPHA ACADEMY
STUDENT HEALTH FORM

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety and learning.

Student Name _____ Grade_____ Sex _____ DOB_____

Name of your child's physician _____ Phone Number_____

MEDICAL HISTORY

Have you ever been told by a physician or health care professional that your child has?:

___Asthma ___Seizure disorder ___Bleeding disorder ___ADD/ADHD
___Diabetes ___Bone/muscle disease ___Skin condition ___Learning disability
___Heart Condition ___Mental condition (i.e. depression, anxiety) ___Other _____

Does your child experience any of the following?:

___Nose bleeds ___Frequent ear aches ___Physical Disability ___Poor appetite
___Frequent headaches ___Fainting spells ___Emotional Concerns ___Other _____
___Frequent stomach aches

Does your child have a life-threatening health condition? Y*___ N___ Describe: _____

*If yes, a meeting with the school administrator is required. North Carolina State Law requires medication or treatment orders and a health care plan be in place prior to starting school.

ALLERGIES

___Plants ___Animals ___Food ___Molds ___Drugs ___Bees/Insects ___Other_____

Please describe the allergic reaction and the treatment for each checked allergy_____

_____

MEDICATION

Does your child take any medicaition? Y___ N___ If yes, name of the medication_____

Purpose_____ Will medication be needed at school? Y*___ N ___

*If your child needs to take medication at school, please complete the authorization form enclosed in this application. This form must be completed prior to starting school.

Does your child wear hearing aides? Y___ N___ Does your child wear glasses or contacts? Y___ N___

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT AT SCHOOL

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered.

Parent/Guardian Signature _____ Date _____