



# GREATER GRACE CHRISTIAN ACADEMY

6077 MORAVIA PARK DRIVE • BALTIMORE, MD 21206 • TEL: (410) 485-0700 • FAX: (410) 325-8884 • WEBSITE: GGCA.ORG

## 2008 – 2009 HEALTH HISTORY FORM

THIS FORM MUST BE COMPLETED ANNUALLY

### STUDENT INFORMATION:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Female  Male

### HEALTH HISTORY:

*Please check if your child has had the following.*

- |                                                     |                                              |                                            |
|-----------------------------------------------------|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Chicken Pox ____/____      | <input type="checkbox"/> Frequent Nose Bleed | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> German measles      | <input type="checkbox"/> Scarlet Fever     |
| <input type="checkbox"/> Blindness                  | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Cerebral Palsy             | <input type="checkbox"/> Measles             | <input type="checkbox"/> Strep Throat      |
| <input type="checkbox"/> Convulsions                | <input type="checkbox"/> Meningitis          | <input type="checkbox"/> Swollen Glands    |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Moodiness           | <input type="checkbox"/> Temper Outburst   |
| <input type="checkbox"/> Diphtheria                 | <input type="checkbox"/> Migraine headache   | <input type="checkbox"/> Tiring Easily     |
| <input type="checkbox"/> Earache/Drainage from ears | <input type="checkbox"/> Mumps               | <input type="checkbox"/> Whooping cough    |
| <input type="checkbox"/> Encephalitis               | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Any Other: _____  |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Osteomyelitis       | _____                                      |
| <input type="checkbox"/> Frequent Sore Throat       | <input type="checkbox"/> Pneumonia           | _____                                      |

### ALLERGIES/MEDICATIONS:

Does your child have any allergies to food or medication? If yes, please list and provide details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child take any medications or receive any treatments on a regular or part-time basis? If yes, please list and provide details:

\_\_\_\_\_  
\_\_\_\_\_

Will your child be taking any medication(s) while in school? If YES, a GGCA Medication At School Permission form must be completed with doctors written orders if applicable. (See Medication Disbursement below) Please list medications:

\_\_\_\_\_  
\_\_\_\_\_

#### **Medication Disbursement:**

**If your child requires medication during school hours (including Tylenol) you must deliver the medication in its original container (marked with child's name) to the school nurse or school secretary. A GGCA Medication At School Permission Form with physician's written orders must be provided stating the reason for medication, dosage requirements, and other instructions. Otherwise, medications will not be dispensed.**

Parent/Guardian Signature

Date