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Education WITH
 AN *Eternal Purpose*

2010 – 2011 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"/> German measles | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Measles | <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Temper Outburst |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Moodiness | <input type="checkbox"/> Tiring Easily |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps | <input type="checkbox"/> Any Other: _____ |
| <input type="checkbox"/> Earache/Drainage from ears | <input type="checkbox"/> Muscular Dystrophy | _____ |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Osteomyelitis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Frequent Nose Bleed | <input type="checkbox"/> Scarlet Fever | |

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 _____