HARVEST CHRISTIAN SCHOOL
HEALTH REPORT 2020-2021

Date: _____

Student's Name: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Allergies: ☐ **Yes** ☐ **No**

Foods and other items allergic to: _____, _____,

_____, _____, _____

Treatment: _____

Asthma / Respiratory Disorders: ☐ **Yes** ☐ **No**

Treatment: _____

Diabetes: ☐ **Yes** ☐ **No** ☐ **Accu-Chek**

Is there anything health wise we need to be aware of to be of greater assistance to your child?

_____ **Treatment:** _____

Physician's Name: _____ **Contact #:** _____

Insurance/Medical Record Number: _____

Parent's Name: _____

Mother

Telephone #: _____ _____ _____

Home **Work** **Cell**

Parent's Name: _____

Father

Telephone #: _____ _____ _____

Home **Work** **Cell**