HARVEST CHRISTIAN SCHOOL

HEALTH REPORT

Date: _____

Student's Name: _____ DOB: _____Gender:_____

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 Required

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

_____

Physician's Name: _____. Phone Number: _____

Insurance/Medical Record Number: _____

Parent's Name: _____Telephone #:

_____Cellphone_____ Work

_____Email Address:_____