Eagle Adventist Christian School & Preschool
538 W. State St., Eagle, ID 83616
School - 208-938-0093, Preschool & FAX - 208-939-5544
eacs12345@gmail.com
www.eagleadventistchristian.com

CHILD HEALTH RECORD

SECTION 1 - TO BE COMPLETETD BY PARENT		
Child's name: Last: First:	Gender: Male ❑ Female ❑	Date of Birth: / /
Does Child have Health Insurance? Yes ❑ No ❑	If Yes, name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Phone	Work /Cell Phone
Parent/Guardian name	Home Phone	Work/Cell Phone
I give my consent for my hcild's Health Provider and child Care Provider/School Nurse to discuss the information on this form.		
Signature/Date	This form may be released to WIC. Yes ❑ No ❑	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER		
Date of Physical Examination:	Results of physical examination normal? Yes ❑ No ❑	
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)	
	Height (must be taken within 30 days for WIC)	
	Head Circumference (if < 2 yrs.)	
	Blood Pressure (if > 3 yrs.)	
IMMUNIZATIONS	Immunization Record Attached ❑ Date Next Immunization Due ❑	

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries * List medical conditions/ongoing surgical concerns:	❑ None ❑ Care Plan Attached	Comments
Medications/Treatments * List medications/treatments:	❑ None ❑ Care Plan Attached	Comments
Limitations to Physical Activity * List limitations/special considerations:	❑ None ❑ Care Plan Attached	Comments
Special Equipment Needs * List items necessary for daily activities:	❑ None ❑ Care Plan Attached	Comments
Allergies/Sensitivities * List allergies	❑ None ❑ Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements * List dietary specifications:	❑ None ❑ Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis * List behavioral/mental health issues/concerns:	❑ None ❑ Care Plan Attached	Comments
Emergency Plans * List emergency plan that might be needed and the sign/symptoms to watch for:	❑ None ❑ Care Plan Attached	Comments

PREVENTATIVE HEALTH SCREENINGS

Type of Screening	Date Performed	Record Value	Type of Screening	Date Performed	Record Value
Hgb/Hct			Hearing		
Lead: ❑ Capillary ❑ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

❑ I have examined the above student and reviewed his/her health history. It is my opionion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unles noted above.

provider (Print)	Health Care Provider Stamp
Signature/Date	