

**Faith Christian Academy**  
**Student Health Form**

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

FCA is willing to accept students with serious illnesses or chronic conditions (such as asthma, allergies, diabetes, attention disorders, heart disorders, leukemia, etc.) provided that:

- The condition has been brought to the attention of the administrator upon submitting an application for admission or upon diagnosis once the student is enrolled.
- FCA is able to meet the physical and/or educational needs of the student within the established program of the school.
- The child is under the care of a physician.
- The parents are willing to remain in close communication with the school regarding needs and changes in the student's condition.
- The parents work with the administration in creating a "care plan" for the student and those involved with the child in caring for his/her special needs.

1. Do you have asthma or any other breathing issues?  Yes  No

*If yes, please explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Do you have any other physical disabilities or special health conditions?  Yes  No

*If yes, please explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Are you allergic to any medications/foods/etc.?  Yes  No

*If yes, describe medication and/or food and reaction to look for:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Do you require any regularly prescribed medication, inhaler or Epi-Pen?  Yes  No

*If yes, please list medications and explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Are you presently under a physician's care for any reason?  Yes  No

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

*If yes, explain:* \_\_\_\_\_  
\_\_\_\_\_

6. Have you ever been medically advised not to participate in any sport or activity?  Yes  No

*If yes, explain:* \_\_\_\_\_  
\_\_\_\_\_

7. Have you had any injury or surgery in the last year causing loss of time from activity or school?

Yes  No

*If yes, explain location (i.e. left knee) and diagnosis* \_\_\_\_\_  
\_\_\_\_\_

8. Do you wear glasses/contact lenses?  Yes  No

*If yes, do you wear them when participating in sports?*  Yes  No

9. Do you have a hearing loss?  Yes  No

*If yes, please explain:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- My child has had **no** immunizations since the beginning of last year school year.
- My child **has** had immunizations since last year and the most recent copy of shot records is attached.
- My child has not been vaccinated and I have completed a Personal or Medical Exemption Form.  
(A new Personal or Medical Exemption form required for every school year)

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature