VALLEY HEIGHTS CHRISTIAN ACADEMY
NORWICH, NEW YORK

TO BE FILLED IN BY PARENT/ GUARDIAN UPON REGISTRATION – Medical Information Sheet

Student Name _____ Grade _____
Last First

Sex: M F Birthdate _____/_____/_____ Birthplace _____
Month Day Year Town/ City State

Home Address _____
Street Town Zip

Mother's Name _____ _____
Home Address if different from above Home Phone Work Phone Cell Phone

Father's Name _____ _____
Home Address if different from above Home Phone Work Phone Cell Phone

Physician's Name _____ Physician's Phone _____

Dentist's Name _____ Dentist's Phone _____

If answer is YES to any of the following, write the item number (1-15) and give the date of occurrence:

_____

_____

1. Any known allergies to, foods bee/insect stings, latex, medicines, etc.? YES NO
   - Allergic to: _____
   - Describe reaction: (local swelling, hives, face swelling, etc.) _____
   - Are emergency meds required? Yes No
2. Sustained any injury or illness which required medical attention and/or hospitalization or surgery? YES NO
   - If YES, our child may need to be cleared with an MD note to participate in sports/gym.
3. Is your child under a physician's care now for an existing problem? YES NO
4. Absence or loss of function for eye, kidney, heart, or other organ? YES NO
5. Requires any ongoing medication at home or school? List above. YES NO
6. Has asthma? YES NO
   - If YES, are emergency meds required? Yes No
7. Had a convulsion, seizures, concussion, loss of consciousness? YES NO
8. Has diabetes? YES NO
9. Has recurrent headaches? Explain above (frequency, intensity, any medication) YES NO
10. Complained of chest pain or fainting during physical exertion? YES NO
11. Has heart disease, murmur, or irregular heart beat? YES NO
12. Wears orthodontic braces? YES NO
    - If YES, is a specialized mouthpiece from an orthodontist required for sports/ PE? Yes No
13. Wears glasses? YES NO
    - For sports? Yes No If Yes, are glasses impact resistant? Yes No
    - Contact lenses? Yes No If Yes, wearing for how long? _____
14. Is there any medical condition or restriction which may be made worse by playing sports/PE? YES NO
15. Required by MD to wear brace/support device to play sports/PE? YES NO

I clarify that the above information is true and accurate and understand that it will be relied upon by VHCA. If medication is prescribed (only for current school year and must be taken during school hours) I authorize school administration to administer the prescribed medication as directed by health care provider (a self-medication release form is available from the school office).

Parent/Legal Guardian Signature_____ Date_____