GREEN CHRISTIAN SCHOOL, INC.
HEALTH HISTORY
VISION, HEARING, SCOLIOSIS SREENING PERMIT

Student Name____

Family Physician____________________________ Phone________________

Family Dentist______________________________ Pnone________________

Is student under physician's care at this time? If so, please explain_________________

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Yes_____ No_____ I hereby give permission for my child to participate in vision/hearing screening.

Yes_____ No_____ I hereby give permission for my child to be screened for scoliosis (curvature of the spine)
Girls-grades 5 & 7 Boys-grade 8

HEALTH HISTORY – Health information will be shared with selected school personnel on a need to know basis.

Does student have a history of any of the following? Please be specific.

ADD/ADHD (diagnosed by a physician)____________________________________

Required medication____

Allergies:____

Asthma/Required medication____

Bone/muscle conditions/scoliosis____

Chicken pox (disease date/vaccinated)_______________________________________

Chronic ear or throat infections____

Diabetes/required medication____

Emotional problems/required medication____________________________________

Fainting/frequent headaches/head injuries or major accidents of any kind (please explain)

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Hearing loss/physical handicap____

Vision (glasses/contact lenses) full/part time?_____________________________________

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Signature of Parent/Guardian Date