

**FLINT HILLS CHRISTIAN SCHOOL AT GREEN
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 _____

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)

Hearing loss/physical handicap _____

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

Signature of Parent/Guardian

Date