BARRINGTON CHRISTIAN ACADEMY
ANNUAL HEALTH FORM

Please complete this form noting the appropriate sections. The following information is needed for your child's school health record and may be shared with appropriate school personnel.

Student Name: _____________________________________ Date of Birth: _____________________ M____ F____

Address: _____________________________________ Home Phone: ___________________ Grade Entering: ____________

Parent(s)/Guardian(s)/Host Parents: ____

Physician Name: _______________________________ Physician Phone: ________________ Last Physical Exam Date: __________

School you attended last year (if new to BCA) __________________________________ What state school was located? _________

I understand that RI law requires that ALL prescription and ALL non-prescription medications, (except for Tylenol, Motrin, and antacid for grades 6-12 at BCA) that need to be given to my child during school hours require written authorization by a physician. See school nurse for Medication Authorization Forms.

First person to be called if my child is sick/injured at school: ___________________________
Phone Number to try first: ____

An age-appropriate dose of acetaminophen **(Tylenol)** may be given to my **6-12th** grader **Yes / No**
An age-appropriate dose of ibuprofen **(Motrin)** may be given to my **6-12th** grader **Yes / No**
An age-appropriate dose of antacid **(Tums)** may be given to my **6-12th** grader **Yes / No**

In the event of an emergency, if I am unable to be reached, I hereby authorize the school to arrange for emergency medical treatment for my child. The information I provided on this form is correct, and I understand that it is my responsibility to update the school nurse regarding any changes to my child's health.
Parent Signature ____ **Date** __________________

(A) This Section is Only for Returning BCA Students in Grades 1,2,4,5,7,8,10,11, & 12:

Please update any **changes to your child's allergies** (i.e. new allergies or allergies that are no longer an issue)
____
Please update any **changes to your child's health/medical conditions** since last September:
____
Please update any major **illnesses, injuries, or operations** since last September:
____

☐ **Check here if there have been NO CHANGES to your child's health since last September**

(B) This Section is for Students in Grades 3, 6, and 9 plus ALL NEW STUDENTS.
Please complete section B on back side of this form.

Does your child have/require any of the following?

	No	Yes		No	Yes
Contacts			Orthopedic Device		
Eyeglasses			Learning Difference		
Ear Tubes			504 Plan		
Hearing Aids			Other		

←New Students and Returning BCA Students in Grades 3, 6, and 9 Please Complete Both Sides→

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DISEASES/CONDITIONS							
	No	**Yes**	**Date**		**No**	**Yes**	**Date**
ADHD/ADD				Heart Condition			
Asthma				Hearing Problem			
Bleeding Disorder				Kidney Problem			
Bone injury/condition				Lead Poisoning			
Cancer				Lyme Disease			
Concussion				Strep Infections			
Cystic Fibrosis				Nosebleeds			
Diabetes				Soiling/Wetting			
Ear Infections				Speech			
Eczema/skin condition				Tuberculosis			
Gastro-intestinal problem				Vision problem			
Headache/ Migraines				Other			
Pneumonia/Bronchitis							

If YES (above), please explain:
____

Does your child have **ALLERGIES?** Yes____ No____

If yes, please state the trigger below:

Bees/insects______________________ **Medication**_______________________________________

Food____________________________ Bacitracin____

Lactose or Gluten_________________ **Latex**____

Environment___________________________________

Explain type of allergic reaction: ____

Does your child require **Benadryl**? Yes___No____

Does your child require an **EpiPen?** Yes___ No____ (For which allergy_______________________________)

Does your child require an **Inhaler?** Yes___ No____

Does your child take **any Medication** on a regular basis? Yes____ No____

Please list medication(s), and dose/reason:

____

Does your child have a **Seizure Disorder**? Yes____ No____

If yes, explain the type of seizure and the date of the last seizure: ____________________________________

Does your child require any **Medical Procedures** while at school? Yes____ No____

If yes, please explain and contact the School Nurse: ____

Is your child **Restricted from PE** or any other physical activities? Yes____ No____

Please Explain ____

Has your child **Experienced a Loss** of a parent, sibling, or significant family member or other trauma? YES___NO___

Explain: ____

Does your child have any **Emotional/Behavioral/Psychological** problems? (I.e. **anxiety, depression,** etc.) YES___NO___

If yes, please explain: ____

Has your child had any **Accidents, Hospitalizations, or Operations** since birth? If yes, please explain and include the date if possible:____

____

Was your child premature? Yes___No ____ Birth Weight: _____________ (disregard if previously answered)

Please include any comments you think might be helpful: ____

____

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