

**BARRINGTON CHRISTIAN ACADEMY
ANNUAL HEALTH FORM**

Please complete this form noting the appropriate sections depending on your child's grade. 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 was school 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 parent/guardian 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 Below 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) Section B Below is Only 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		

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(Section B Continued on this page)	DISEASES/CONDITIONS						
	No	Yes	Date		No	Yes	Date
ADHD				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 (circle)				Other			
Pneumonia/Bronchitis							

If YES (above), please explain:

Does your child have **ALLERGIES**? Yes ___ No ___

If yes, please state the trigger below:

Bees/insects _____

Food _____

Lactose or Gluten _____

Medication _____

Bacitracin _____

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: _____