



# MEDICAL HISTORY and CONSENT FORM

This form should be filled out by the  
child's parent or legal guardian.

**Name of Child** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Sex:** \_\_\_\_\_  
**Grade** \_\_\_\_\_  
**Address** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_  
Email \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  
Email \_\_\_\_\_  
Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
Work Phone # \_\_\_\_\_

**Health concerns:** Does your child have any health concerns Pine Park Christian Academy needs to be aware of? Yes \_\_\_\_\_ No \_\_\_\_\_

If YES, please  
describe. \_\_\_\_\_  
\_\_\_\_\_

Can your child participate in all school activities? Yes \_\_\_\_\_ No \_\_\_\_\_

**Allergies:** Does your child have any allergies? Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, what is your child allergic to?  
\_\_\_\_\_  
\_\_\_\_\_

Does your child carry an Epi Pen? Yes \_\_\_\_\_ No \_\_\_\_\_

**Medication:** Does your child currently take medications? Yes \_\_\_\_\_ No \_\_\_\_\_  
If YES, what medicine?  
\_\_\_\_\_

**Past medical history:** Date of last doctor's visit \_\_\_\_\_

Does or has your child received medical care for any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Orthopedic
<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Seizure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other_____
<input type="checkbox"/> Heart Disease	_____
<input type="checkbox"/> Kidney Disease	_____
<input type="checkbox"/> Mental Health	

**Primary care provider:** Name\_\_\_\_\_

Clinic/Practice Name\_\_\_\_\_

**Other provider:** Name\_\_\_\_\_

Clinic/Practice Name\_\_\_\_\_

**Health insurance type:** Private Insurance\_\_\_\_ Other\_\_\_\_\_

Pine Park Christian Academy has permission to give my child the following **over-the-counter medications:**

Acetaminophen (same ingredient as TYLENOL) Yes\_\_\_\_\_ No\_\_\_\_\_

Ibuprofen (same ingredient as ADVIL) Yes\_\_\_\_\_ No\_\_\_\_\_

Pine Park Christian Academy has permission to share information with emergency responders and health care professionals as they determine appropriate for my child's health and safety. Yes\_\_\_\_\_ No\_\_\_\_\_

Pine Park Christian Academy has permission to share the following information about my child with my child's health care provider:

Childhood immunizations Yes\_\_\_\_\_ No\_\_\_\_\_

Mental health/counseling concerns Yes\_\_\_\_\_ No\_\_\_\_\_

Prescribed medications Yes\_\_\_\_\_ No\_\_\_\_\_

Other: \_\_\_\_\_ Yes\_\_\_\_\_ No\_\_\_\_\_

My child's medical conditions Yes\_\_\_\_\_ No\_\_\_\_\_

Mother's Signature\_\_\_\_\_

Father's Signature\_\_\_\_\_