

NMB Christian School

Medical Information

Student's Name _____ Date of Birth _____

Emergency Contact #1 _____ Phone(____) _____
Relationship to student _____ Cell(____) _____

Emergency Contact #2 _____ Phone(____) _____
Relationship to student _____ Cell(____) _____

PAST DISEASES-If your child has had any of the following, state age when child had them:

- | | | | |
|---------------------|----------------------------|-----------------------|--------------------------|
| Mumps _____ | Whooping Cough _____ | Hay Fever _____ | Heart Problems _____ |
| Measles _____ | Rheumatic Fever _____ | Pneumonia _____ | Vision Problems _____ |
| Polio _____ | Venereal Disease _____ | Scarlet Fever _____ | Bleeding Problems _____ |
| Diabetes _____ | Bone/Muscle Problems _____ | Chicken Pox _____ | Dental Problems _____ |
| Asthma _____ | Convulsions _____ | Ear Discharge _____ | Urinary/Bladder _____ |
| Diphtheria _____ | Cancer/Leukemia _____ | Skin Problems _____ | Attention/Learning _____ |
| Heart Disease _____ | Sickle Cell Anemia _____ | Cystic Fibrosis _____ | Cerebral Palsy _____ |
| Seizures _____ | Emotional/Behavior _____ | Bowel Problems _____ | Meningitis _____ |

RECENT DISABILITIES-Please check any that have been noted in child recently:

- | | | | |
|----------------------------|------------------------|------------------------|--------------------|
| Frequent Colds _____ | Fainting Spells _____ | Hearing Problems _____ | Tires Easily _____ |
| Frequent Sore Throat _____ | Abdominal Pains _____ | Poor Vision _____ | Allergies _____ |
| Frequent Urination _____ | Breath Shortness _____ | Leg Pains _____ | Hernia _____ |
| Frequent Sties _____ | Persistent Cough _____ | Ringworm _____ | Nose Bleeds _____ |
| Crippling Conditions _____ | Dental Defects _____ | Speech Problems _____ | Dizziness _____ |

Does your child have a disability due to illness or accident? _____

Has your child had a skin test for tuberculosis? _____

PERSONAL RECORD-Please answer all of the following:

- Is the child shy? _____ Overactive? _____ Bite Fingernails? _____ Suck Thumb? _____
 Play well with others? _____ Have many fears? _____ Have temper tantrums? _____
 Eat Breakfast? _____ When is the child's regular bedtime? _____ When is the child's
 regular rising time? _____ Does the child wear contacts or glasses? _____ Which? _____

**List any allergies or reactions your child may have to any medications or other substances.
(ex. Asprin, latex, bee stings, etc.)** _____

Emergency plan for child with medical conditions, allergies, asthma, etc.

List all daily medications: _____

Does your child have any impairment or function that would limit his/her participation in any physical activity? If so, explain: **NOTE: No student will be excused from P.E. without a written excuse from a physician.**

I, _____, release and waive, and further agree to indemnify, hold harmless or reimburse North Myrtle Beach Christian School, the individual members, have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during, or in connection with my child's receiving medication(s) or emergency medical treatment at school or at any school sponsored activity.

Parent/Guardian Signature _____ Date: _____

IF MEDICATION NEEDS TO BE ADMINISTERED, PLEASE COMPLETE A MEDICATION CONSENT FORM FROM THE SCHOOL OFFICE.