VALLEY HARVEST CHRISTIAN SCHOOL
HEALTH HISTORY INFORMATION FORM

Date: _____ Student Name: _____ Birth date: _____/_____/_____

Gender: Male or Female **School Year: 2026-2027**

Home Address: _____

City: _____ State: _____ Zip code: _____

Does your child have *ANY* allergies (food, medications, or environmental factors)? Yes _____ No_____

If yes please list *ALL* allergies, type of reaction, and previous treatment for reaction:

_____

_____

Please provide information relative your child's vision and hearing below

	Yes	No	Type	Requires corrective equipment (lens or aides) (Yes/No) If yes, please specify
Eye/Vision Problems				
Ear/Hearing Problems				

Please provide information relative to the following health concerns of your child and return:

HEALTH PROBLEM/HISTORY OF	Yes	No	Type	Currently taking medications or being treated (yes/no)
Heart Problems (including blood pressure, cholesterol, congenital, or others)				
Asthma				
Thyroid Disease				
Cancer				
Mental Health Disorder				
Stomach/Intestinal				
Elimination (bowel or urination)				
Diabetes/Endocrine (low or high blood sugar problems)				
Concentration or Behavioral Concerns (such as ADD, ADHD, Autism, or others)				
Bone/Joint/Ligament Injury or Fractures				
Seizure Disorder				
Other Health History/Concerns				

List and describe any condition not listed above.

_____

_____

Hospital/**Surgical History(please describe any hospitalizations/surgeries)**

_____

_____

Current Medication List (LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS TAKEN AT HOME AND SCHOOL)

Medication Name	Dose & Route	Frequency	Reason for Taking	Does medication need to be taken at school? If yes, specify time medication needs to be taken

If your child requires ***ANY*** medication to be taken during the school day, please be sure to sign the medication administration form giving permission for school to do so. Your child's medications ***MUST*** be in original labeled bottles, turned in to, and kept in the administrator's office for safety reasons.

Valley Harvest
Christian School

PERMISSION FOR MEDICATION ADMINISTRATION

(Please Complete the Following as Appropriate for Your Child)

_____ (Parent Initial's) ***ONLY*** if your child has prescription medication(s) that need(s) to be administered during school day.

Name of Prescription Medication/Dose

If there are prescription medications to be administered during the school day, those medications will have to be administered per the provider's prescribed instructions listed on the medication bottle unless otherwise noted in a note from prescribing provider. These to be given directly to the principal on the first day of school.

Over the counter medication(s) that need(s) to be or can be administered during school day. If this is true for your child, please specify the information below:

Name of Non-Prescription/OTC Medication	Dose & Route	Frequency	Reason(s) to be Taken

I, _____ (parent/guardian name) give my permission for designated/trained staff at Valley Harvest Christian School to administer medications to _____ (child's full name) during the school day as listed above.

Printed Name of Parent/Guardian	
Signature of Parent/Guardian	
Date Signed	

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Christian School

AUTHORIZATION FOR MEDICAL TREATMENT FORM

I, being the parent and/or legal guardian of _____ (child's full name), do hereby authorize Valley Harvest Christian School administration and staff to seek and obtain medical care for my child in the event that my child needs emergency medical care until I can be contacted and present with my child.

I authorize the release of health information concerning my child that is on file with the school to any emergency personnel and medical care facility for health and safety reasons by Valley Harvest Christian School administration.

I agree to be financially responsible for the cost of any medical care provided to my child under this Authorization. My child's current health insurance information is below:

Name of Insurance Company	
Name of Policy Holder	
Relationship of Policy Holder to Child	
Insurance Policy ID #	

I verify with my signature below that I have:

1. authorized for medical treatment and release of information.
2. agreed to be financially responsible for medical care provided.
3. completed and reviewed all information to be accurate.

Printed Name of Parent/Guardian	
Signature of Parent/Guardian	
Date Signed	