ARGOSY
COLLEGIATE CHARTER SCHOOL

# Health Profile 2018-2019

Scholar Name:_____ Date of Birth:_____ Grade:_____

Emergency Contact:_____ Phone:_____

Relationship to Scholar:_____

***Please fill out completely. If an area is not applicable, please write "N/A."**

| | | |
|---|---|---|
| Date of Last Physical: | Doctor's Office: | Primary Care Physician's Name: |
| Date of Last Dental Exam: | Dentist Office: | Are you interested in more information about free dental cleaning?<br>Circle: YES NO |
| Does your child wear glasses?<br>Circle: YES NO | If Yes, Date of last exam: | Eye Doctor's Name: |
| **Anaphylactic Allergy*:**<br><br>(Doctor is aware and Epi-pen is prescribed)*Please indicate the allergy and the reaction that occurs. | Drug Intolerances** and Side Effects:<br><br>Circle if apply:<br>-Stomach upset<br>-Hives<br>-Other: | Food Intolerances*** and Side Effects: |

*Anaphylaxis is a severe, potentially life-threatening allergic reaction. It can occur within seconds or minutes of exposure to something you're allergic to, such as a peanut or the venom from a bee sting. Some symptoms include: skin reactions, including hives along with itching, and flushed or pale skin, constriction of the airways and swollen tongue or throat, which can cause wheezing and trouble breathing, a weak and rapid pulse, nausea, vomiting or diarrhea, dizziness or fainting.

** A drug intolerance is different from a drug allergy, since it doesn't involve an immune reaction. A drug intolerance is an adverse effect from a drug. Common Drug intolerances include drowsiness and stomach upset.

*** When a food irritates your stomach or your body can't properly digest it, that's an intolerance. Some symptoms include gas, cramps, or bloating, heartburn, headaches. Irritability or nervousness.

Please circle if your child has any of the following allergies:

-Seasonal
-Cat
-Dogs
-Other: _____

If yes, does your child take medication, either prescribed or over the counter? YES NO

Medication name, dosage, and frequency: _____

Is this medication year round or only seasonal? _____

Please circle if your child has any of the following medical conditions **diagnosed by a Doctor:**

-ADD
-ADHD
-Asthma
-Autism
-BiPolar Disorder
-Bowel Problems
-Dental Problems
-Diabetes
-Dyslexia/Learning Disorder
-Ear Infections
-Eating Disorder
-Epilepsy/Seizure Disorder
-Heart Condition
-Hearing Difficulty/Problems
-Kidney/Urinary Tract Disorder
-Menstrual Problems
-Migraines
-Muscular Disorder
-Psychological Disorder
-Post-Concussion Syndrome
-Respiratory/Sinus Disorder
-Other:

Please Explain:

_____

_____

Please add any additional information about your child, for example he/she tends to get headaches but it hasn't been medically diagnosed as a migraine. _____

_____