Health Care Assessment Form
Sunnydale Adventist Academy

Please complete the following and return to the administration office or school nurse.

Name: _____
Last First Middle

Male: _____ Female: _____ Date of Birth: _____

Parent/Guardian: _____

Phone Number: Home_____ Cell_____

Please Check Appropriate Boxes Below that Pertain to Your Child:

- ☐ Seasonal Allergies
- ☐ Severe Allergy
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Condition
- ☐ Bone or Joint Problems
- ☐ Nosebleeds
- ☐ Depression
- ☐ Eating Disorder
- ☐ Blood Disorder
- ☐ Anxiety
- ☐ Headaches
- ☐ Mental Health Disorder
- ☐ History of Suicide Attempt

Please explain any of the boxes checked above:_____

_____

_____

Please list any allergies and reactions the student may have:_____

_____

Diet restrictions: Vegan ( ) Gluten free ( ) Other _____

Childhood diseases, serious illness, and injuries: _____

_____

Surgeries: _____

Condition that prevents PE participation: _____
If student requires medication at school, or a change in PE participation, please notify the school office or appropriate dean. Health information will be shared with the school staff on a need to know basis.

_____ _____
Parent/Legal Guardian signature Date

Updated 01/04/23