

✠ Sunrise Beach School ✠

State-Approved Christian School Pre-K-12 / Accredited / Non-Profit 501(c)3

Telephone: (360) 791-8348 / (360) 866-1343 / Fax: (360) 866-1824

6101 Mink Street Northwest Olympia, WA 98502-9542

E-Mail: Info@SunriseBeachSchool.org

Sunrise Beach High School

HEALTH PROFILE

The information requested on this health profile will be kept confidential and will be included in your child's health record by the school. We are asking for health related information as we believe this to be helpful in providing for your child's health, safety, and optimal learning experience. This information will only be shared with other school personnel that contribute to the health, safety, learning, and well being of your child.

General Information: (please print)

Name (first, middle, last) _____ Nickname _____
Grade _____ Birth Date _____ Place of Birth _____
Address _____ Phone _____
Father's/ Guardian's Name _____ Phone _____
Address _____ Phone _____
Mother's/Guardian's Name _____ Phone _____
Address _____ Phone _____
Siblings Attending SBS/SBHS _____
#1-Emergency Contact Person _____
Phone _____ Relationship to Student _____
#2-Emergency Contact Person _____
Phone _____ Relationship to Student _____
#3-Emergency Contact Person _____
Phone _____ Relationship to Student _____
Medical Insurance Co. _____ ID Number _____
Subscriber's Name _____ Policy Number _____

Student Health

Student's Doctor _____ Phone _____
Health Concern(s) _____

ALLERGIES _____

Reaction Type _____

Medication Needed _____

CURRENT MEDICATION(S) _____

Reason for taking medication _____

Will this medication need to be administered while child is attending school? _____

If so, name of medication & dosage _____

**Please obtain a Physician Request for Medication Form, have it signed,
and return form to SBS/SBHS prior to attending classes.**

HAS YOUR CHILD HAD (OR CURRENTLY HAS) ANY OF THE FOLLOWING?

At (L), please write "P" for past or "C" for current - next to all that apply.

At (R), please write date and/or student's age when last occurred.

ADD / ADHD	Fever over 104	Neurological Condition
Allergy	German Measles	Pleurisy
Anemia	Head Injury	Pneumonia
Asberger's Syndrome	Heart Disease	Polio
Asthma	Hepatitis	Rheumatic Fever
Convulsions	Hernia	Scarlet Fever
Diabetes	Influenza	Seizure Disorder
Diphtheria	Measles	Tonsillitis
Eczema	Meningitis	Tuberculosis
Encephalitis	Mononucleosis	Whooping Cough
Epilepsy	Mumps	Other:
ILLNESS/ DIAGNOSIS		
Describe		
Medication		
ILLNESS/ DIAGNOSIS		
Describe		
Medication		
HOSPITALIZATION(S)		
SERIOUS ACCIDENT(S)		
JOINT OR MUSCLE PROBLEM(S)		

HOW WOULD YOU DESCRIBE YOUR CHILD? (Yes, Few, Some, Frequent)

_____ Frequent colds	_____ Frequent stomachaches	_____ Many fears
_____ Sore throats	_____ Frequent toothaches	_____ Nervousness
_____ Persistent cough	_____ Angers easily	_____ Worries
_____ Nosebleeds	_____ Frequent pain in legs	_____ Tires easily
_____ Noise Sensitivity	_____ Bathroom issues	_____ Cries easily
_____ Ear pain	_____ Speech problems	_____ Ear infection
_____ Vision problems	_____ Wears glasses or contacts	_____ ↓ Attention
_____ Hearing difficulty	_____ Headaches/ or migraines	_____ Anxieties

MEDICAL AND DENTAL CARE

Student's Doctor _____ Phone _____
 Student's Dentist _____ Phone _____

SPECIAL HEALTH NEEDS

Does your child have any special health needs or problems the school should know about?

Please describe: _____

I attest that the information on this health form is accurate to the best of my knowledge.

 (Parent Signature / Date Signed)