

CALVARY CHRISTIAN SCHOOL

4345 Inn Street, Triangle, VA 22172 • 703.441.6868



ALLERGY & HEALTH INFORMATION CARD • 2024

STUDENT PROFILE INFORMATION			
STUDENT LEGAL NAME (LAST, FIRST, MIDDLE)			
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH	GRADE	
EMERGENCY CONTACTS			
NAME	RELATIONSHIP	HOME PHONE	CELL PHONE
STUDENT HEALTH INFORMATION			
<input type="checkbox"/> Does not have any known food allergies or health concerns.			
Has food allergies. (please list) <input type="checkbox"/> _____ <input type="checkbox"/> <i>This allergy is life-threatening and requires immediate medical attention. I understand it is my responsibility to provide the school with appropriate documentation and medicine(s) as listed above.</i>			
Has allergies other than food. (please list) <input type="checkbox"/> _____ <input type="checkbox"/> <i>This allergy is life-threatening and requires immediate medical attention. I understand it is my responsibility to provide the school with appropriate documentation and medicine(s) as listed above.</i>			
<input type="checkbox"/> Is on the following medications (dose, time given) on a regular basis. (please list) _____			
<input type="checkbox"/> Has additional health concerns. (please list) _____			
FAMILY HEALTH CARE PROVIDER INFORMATION			
MEDICAL		DENTAL	
Physician Name		Dentist Name	
Address		Address	
City, State, ZIP		City, State, ZIP	
Office Phone		Office Phone	
HEALTH INSURANCE			
Company		Hospital	
Plan		Comments	
Group			

PARENT OR LEGAL GUARDIAN SIGNATURE

DATE

EMERGENCY PHONE NO.

FOR OFFICE ONLY Consent for Taking Medications at School

<input type="checkbox"/> Health Care Action Plan BASIC	<input type="checkbox"/> Health Care Action Plan ALLERGIES	<input type="checkbox"/> Health Care Action Plan ASTHMA	<input type="checkbox"/> Health Care Action Plan MIGRAINES	<input type="checkbox"/> Health Care Action Plan SEIZURE DISORDER
--	--	---	--	---