

**NO BOUNDARIES  
HEALTH INFORMATION**

Child's Name: (First)\_\_\_\_\_ (Last)\_\_\_\_\_

Age:\_\_\_\_\_ Birth-date:\_\_\_\_\_ Male: \_\_\_ Female:\_\_\_

Grade in school:\_\_\_\_\_ School child is attending:\_\_\_\_\_

Person Responsible for child:

Mother:\_\_\_\_\_

Father:\_\_\_\_\_

Other:\_\_\_\_\_ Relationship:\_\_\_\_\_

Does the above named person have legal custody of the child? Yes:\_\_\_ No:\_\_\_

If not, who is the legal guardian?\_\_\_\_\_

Address where child lives:\_\_\_\_\_

City:\_\_\_\_\_ Zip:\_\_\_\_\_

Phone number: Home:\_\_\_\_\_

Work:\_\_\_\_\_

Cell:\_\_\_\_\_

Disease/Disorder/Condition:\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please mark any of the following medical conditions or problems that apply to your child. (You have had in the past or now have).**

- |   |  |
|---|--|
| <input type="checkbox"/> ADD                        | <input type="checkbox"/> Hepatitis           |
| <input type="checkbox"/> ADHD                       | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Kidney condition    |
| <input type="checkbox"/> Bowel problems             | <input type="checkbox"/> Lung problems       |
| <input type="checkbox"/> Brain injury               | <input type="checkbox"/> Measles             |
| <input type="checkbox"/> Chicken pox                | <input type="checkbox"/> Mental disorder     |
| <input type="checkbox"/> Connective tissue disorder | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> Dental problems            | <input type="checkbox"/> Mumps               |
| <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Hearing impaired           | <input type="checkbox"/> Skin problems       |
| <input type="checkbox"/> Heart condition            |  |

Does the child require special assistance, equipment, or other needs: \_\_\_\_\_  
\_\_\_\_\_

Does the child have medication that is taken on an AS NEEDED basis that must stay with the child? Yes:\_\_\_ No:\_\_\_  
If yes, what are the medications and please give detailed instructions on how medications are to be given.

\_\_\_\_\_  
\_\_\_\_\_

Is there special equipment that must stay with the child? Yes:\_\_\_ No:\_\_\_  
If yes, does the equipment require any special training? Yes:\_\_\_ No:\_\_\_  
Please list what equipment is used and give detailed instructions on how to use, UNLESS equipment requires special training. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**VISION:**

Does the child have difficulty seeing? Yes:\_\_\_ No:\_\_\_  
Does the child wear glasses? Yes:\_\_\_ No:\_\_\_  
Does the child have glaucoma? Yes:\_\_\_ No:\_\_\_  
Does the child have a prescription for eye medication? Yes:\_\_\_ No:\_\_\_

**COMMUNICATION:**

Does the child have difficulty hearing? Yes:\_\_\_ No:\_\_\_  
If so, which ear is better? Right:\_\_\_ Left:\_\_\_  
Does the child wear a hearing aid? Yes:\_\_\_ No:\_\_\_ (Right:\_\_\_ Left:\_\_\_ Both:\_\_\_)  
Does the child read lips? Yes:\_\_\_ No:\_\_\_ How Well? \_\_\_\_\_  
Does the child know sign language? Yes:\_\_\_ No:\_\_\_ How well? \_\_\_\_\_  
Does the child have impaired speech? Yes:\_\_\_ No:\_\_\_

Does the child use pencil and paper? Yes:\_\_\_ No:\_\_\_  
Can the child read? Yes:\_\_\_ No:\_\_\_  
Can the child write? Yes:\_\_\_ No:\_\_\_  
Is there someone to help the child communicate? Yes:\_\_\_ No:\_\_\_

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**TEETH:**

Does the child have any dental conditions that would need to be addressed during Sunday School? Yes:\_\_\_ No:\_\_\_  
Please explain:\_\_\_\_\_

**DIETARY/NUTRITION:**

Does the child have trouble swallowing? Yes:\_\_\_ No:\_\_\_  
Please explain:\_\_\_\_\_

Are there foods that the child has trouble eating or is the child allergic to certain foods?  
Yes:\_\_\_ No:\_\_\_  
Please explain:\_\_\_\_\_

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What happens when the child eats these foods?\_\_\_\_\_

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Is the child permitted to eat chocolate? Yes:\_\_\_ No:\_\_\_  
Will eating chocolate cause the child to have a seizure? Yes:\_\_\_ No:\_\_\_

Has the doctor ever told the child not to eat certain foods? Yes:\_\_\_ No:\_\_\_  
Please explain:\_\_\_\_\_

Does the child take a food supplement? Yes:\_\_\_ No:\_\_\_

Is the child diabetic? Yes:\_\_\_ No:\_\_\_

Does the child take medication for diabetes? Yes:\_\_\_ No:\_\_\_  
Pills? Yes:\_\_\_ No:\_\_\_ How often does the child take pills?\_\_\_\_\_

Injections? Yes:\_\_\_ No:\_\_\_ How often does the child take injections?\_\_\_\_\_

Is the child on an insulin pump? Yes:\_\_\_ No:\_\_\_

Can the child use the pump without assistance? Yes:\_\_\_ No:\_\_\_

If no, is someone available to train a staff member how to assist with the pump?

Yes:\_\_\_ No:\_\_\_

How often does the child check his/her blood sugar? \_\_\_\_\_

Does the child need assistance checking his/her blood sugar? \_\_\_\_\_

If yes, is someone available to train a staff member how to check the child's blood sugar?

Yes:\_\_\_ No:\_\_\_

Has a doctor prescribed more fluid intake? Yes: \_\_\_ No: \_\_\_

Less fluid intake? Yes: \_\_\_ No: \_\_\_

Does the child have to restrict his/her salt intake? Yes: \_\_\_ No: \_\_\_

**RESPIRATION AND CARDIOVASCULAR:**

Does the child have difficulty breathing at any time? Yes: \_\_\_ No: \_\_\_

Does the child have asthma? Yes: \_\_\_ No: \_\_\_

Does the child take medication for asthma? Yes: \_\_\_ No: \_\_\_

If yes, how often and what type of medication? \_\_\_\_\_

Does the child take medication for fluid retention? Yes: \_\_\_ No: \_\_\_

If yes, how often and what type of medication? \_\_\_\_\_

Does the child have high blood pressure? Yes: \_\_\_ No: \_\_\_

If yes, does the child take medication and how often? \_\_\_\_\_

Does the child take heart medication? Yes: \_\_\_ No: \_\_\_

If yes, how often and what type of medication? \_\_\_\_\_

Does the child have problems with vertigo? Yes: \_\_\_ No: \_\_\_

Does the child have problems with tremors? Yes: \_\_\_ No: \_\_\_

Has the child had a stroke? Yes: \_\_\_ No: \_\_\_

Please explain. \_\_\_\_\_

What are the child's abilities after the stroke? \_\_\_\_\_

**ELIMINATION:**

Is the child able to toilet independently? Yes: \_\_\_ No: \_\_\_

Does the child have any kidney problems? Yes: \_\_\_ No: \_\_\_

Does the child have trouble with frequent urination? Yes: \_\_\_ No: \_\_\_

Does the child need assistance going to the bathroom? Yes: \_\_\_ No: \_\_\_

Does the child wear protective garments? Yes: \_\_\_ No: \_\_\_

Has the child's doctor prescribed medications for frequent urination? Yes: \_\_\_ No: \_\_\_

Does the child have a permanent Foley Catheter? Yes: \_\_\_ No: \_\_\_

Who helps the child take care of the catheter to keep it clean and free from bacteria? \_\_\_\_\_

Does the child have problems with menstrual periods? Yes: \_\_\_ No: \_\_\_

**ACTIVITY AND MOBILITY:**

Does the child have free use of both arms and legs? Yes: \_\_\_ No: \_\_\_

Does the child have trouble with mobility? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

Does the child have ambulatory aides, such as artificial limbs, canes, walkers, braces, wheelchair?

Yes: \_\_\_ No: \_\_\_ Please explain: \_\_\_\_\_

Is the child's amount of activity limited in any way? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

Does the child have trouble getting in and out of chairs? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

Does the child have trouble stepping up and down? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

Is the child prone to falling? Yes: \_\_\_ No: \_\_\_ Please explain: \_\_\_\_\_

Does the child have problems with arthritis? Yes: \_\_\_ No: \_\_\_

If yes, does the arthritis cause a problem with activity? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

Has the child ever had broken bones? Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

**SKIN:**

Does the child have trouble with dry skin? Yes: \_\_\_ No: \_\_\_

What does the child do for dry skin? \_\_\_\_\_

Are there any other skin conditions that must be attended to during Sunday School?

Yes: \_\_\_ No: \_\_\_

Please explain: \_\_\_\_\_

**MENTAL/EMOTIONAL STATUS:**

Does the child have mental retardation or delayed development? Yes: \_\_\_ No: \_\_\_

What is the child's functional age level? \_\_\_\_\_

In what specific areas is the child delayed? (Speech, motor development, etc) \_\_\_\_\_

Does the child have ADHD or ADD? Yes: \_\_\_ No: \_\_\_

Does the child have any mental health issues (depression, obsessive/compulsive disorder, anxiety, etc.)? \_\_\_\_\_

Does the child take medications for any of the above? Yes: \_\_\_ No: \_\_\_

Please list medications: \_\_\_\_\_



**EMERGENCY CONTACTS FOR** \_\_\_\_\_  
(Name of child)

|             |                         |
|-------------|-------------------------|
| Name:       | _____                   |
| Address:    | _____                   |
| City:       | _____ Zip Code: _____   |
| Home Phone: | _____ Work Phone: _____ |

|             |                         |
|-------------|-------------------------|
| Name:       | _____                   |
| Address:    | _____                   |
| City:       | _____ Zip Code: _____   |
| Home Phone: | _____ Work Phone: _____ |
| Cell Phone: | _____                   |

|             |                         |
|-------------|-------------------------|
| Name:       | _____                   |
| Address:    | _____                   |
| City:       | _____ Zip Code: _____   |
| Home Phone: | _____ Work Phone: _____ |
| Cell Phone: | _____                   |

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| OFFICE USE ONLY                |
| REVIEWED BY: _____ DATE: _____ |

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