CORNERSTONE CHRISTIAN ACADEMY

STUDENT HEALTH INFORMATION
PRESCHOOL-12TH GRADE
2018/2019 SCHOOL YEAR

STUDENT INFORMATION

Name: _____ Date of Birth: _____ Grade: _____

Parent Name: _____

Physician's Name: _____

ALLERGIES

Does the student have any allergies? _____ Is an Epi-pen required? _____

What causes an allergic reaction? _____

_____

What are the symptoms of the reaction? _____

_____

What is the treatment for the reaction? _____

_____

ATHSMA

Does the student have asthma? _____

What is the treatment for asthma? _____

Does the student need an inhaler at school? _____

SEIZURES

Does the student have seizures? _____

Type of seizure: _____

Date of last seizure: _____

OTHER HEALTH CONCERNS (include ADHD, depression, heart, blood or orthopedic conditions, etc)

_____

_____

_____

ROUTINE MEDICATIONS PRESCRIBED & OVER THE COUNTER

_____

_____

_____

The only over the counter medication that will be administered is Tylenol.

Vision/Eye Problems? (Glasses/Contacts) _____
Hearing Problems? _____ **Hearing Aid?** _____ **Right Ear** _____ **Left Ear** _____

For prescription medications to be administered at school the **Physician Statement of Need** form must be completed and sign by the student's doctor. The medication must be in the original bottle with the dose and interval to be administered.

If you have specific issues or concerns about your child's health, please contact the school nurse.