Date_____

Cornerstone Christian Academy Student Health Information

Student Name_____DOB_____Grade_____

Parent Name_____Physician's Name_____

Allergies Yes____No____ Requires Epi-pen? Yes____No____

1.What causes an allergic reaction?_____

2.What are the symptoms of the reaction?_____

3.What is the treatment for the reaction?_____

Asthma Yes___No___

1. What is the treatment for asthma?_____

2.Dose your child need an inhaler at school? Yes___No___

Seizures Yes___No___ **Type of seizure_____Date of last seizure_____**

Other Health Concerns (include ADHD, depression, heart, blood or orthopedic conditions, ect.)

_____

_____

_____

Routine Medications Prescribed & Over the Counter

_____

_____

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

Eye/Vision problems? Glasses/Contacts Yes___ No___

Hearing problems? Hearing aid Yes___No___ **Right ear_____Left ear_____**

For prescription medications to be administered at school the **Physician Statement of Need** form must be completed and signed 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.