



# COMMUNITY CHRISTIAN SCHOOL

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## Health Form

Student's Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last

First

Middle

Does your child have any of the following?

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> A.D.D.       | <input type="checkbox"/> A.D.H.D              | <input type="checkbox"/> Allergies (foods, insects, medications, etc.) |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Been Suicidal        | <input type="checkbox"/> Bleeding Disorder                             |
| <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Chicken Pox          | <input type="checkbox"/> Depression                                    |
| <input type="checkbox"/> Disabilities | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Head Injury                                   |
| <input type="checkbox"/> Fainting     | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Headaches                                     |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> Injuries                                      |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Muscular Disorders                            |
| <input type="checkbox"/> Nose Bleeds  | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Ulcers       | <input type="checkbox"/> Vision Loss          | <input type="checkbox"/> Other   |

Please explain thoroughly any checked above: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship \_\_\_\_\_ Is applicant taking medication on a regular basis?  
Yes  No

Name of medication \_\_\_\_\_ Reason \_\_\_\_\_

Name of medication \_\_\_\_\_ Reason \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Hospital Choice \_\_\_\_\_ Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_

***If no one can be reached at the above numbers, by signing below I hereby give permission for a school official to call 911 or take my child to a physician or hospital for treatment. I understand that this is for emergencies only and I will be responsible for any charges that may occur.***

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_

Date