#8 - Student Health Record

School: Community Christian Academy Student Name: _____
Date: _____/_____/_____

(*Please Print*)

Please Print All Information Legibly

Child's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____) _____—_____ Phone Belongs to: _____

Family Physician: _____ Phone #: (_____) _____—_____

Has your child ever been diagnosed or treated for any of the following illnesses or disorders:

COVID-19 _____ Measles _____ Mumps _____ Chicken Pox _____ Flu _____

Meningitis _____ Diabetes _____ Epilepsy _____ Cancer _____

AIDS (or HIV Infection) _____ Whooping Cough _____

Eye, ear, nose or throat problems _____ Asthma _____ Hay Fever _____

Allergies _____ List any allergies _____

Have you or your child been in contact with anyone diagnosed with COVID-19? ❑Yes ❑No

_____

List any other medical disorders or problems: (*Use Separate Sheet if Necessary*)

(Continue On Back)

List **ALL** mediations that your child is on, and the purpose of the drug: (*Use Separate Sheet if Necessary*)

1. Medicine Name: _____

   Purpose: _____

2. Medicine Name: _____

   Purpose: _____

3. Medicine Name: _____

   Purpose: _____

4. Medicine Name: _____

   Purpose: _____

5. Medicine Name: _____

   Purpose: _____

I hereby declare the above health record for my child to be true and accurate to the best of my knowledge. By this form, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, or any other institution or person that has any information about my child's medical health, to give Community Christian Academy any such information (including information about AIDS or HIV infection). This form is valid for the entire time my child is enrolled at Community Christian Academy.

Signed: _____ Relation to Child: _____

Date: _____/_____/_____