

C.C.A. CONFIDENTIAL HEALTH HISTORY 2010-2011

Name of Student: _____ Grade: _____
Child's Physician: _____
Physician's Address: _____
City: _____ State: _____ ZIP: _____
Physician's Telephone: _____

HEALTH REQUIREMENTS

ADMISSION REQUIREMENT: The following must be presented when your child is registered to attend **CELINA CHRISTIAN ACADEMY**:

- HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above-named child within the past year and find that he/she is physically able to participate in school activities. **A signed and dated copy of the child's most recent vaccination record is attached.** (Must be stamped with address of health-care professional.) If child is age four and over, a copy of the latest hearing and vision testing is also attached.

Date: _____

Signature of Health-Care Professional

- WAIVER:** Medical diagnosis and treatment conflict with the tenets and practices of our recognized religious organization, to which I adhere to or am a member. I have attached a signed and dated affidavit stating this fact.

HEALTH HISTORY (PLEASE LEAVE NO BLANKS)

Does your child have any allergies? Yes No

If so, what?: _____

How are allergies manifested (rash, swelling, upset stomach, etc.)? _____

List any dietary restrictions: _____

List any serious illnesses diagnosed or treated in the past twelve months (asthma, diabetes, ADHD, immune disorders, etc.): _____

List any treatment plans of any chronic conditions for which your child is being treated (asthma, diabetes, ADHD, immune disorders, etc.): _____

List any recent (last twelve months) family events that you think might affect your child's health or performance in school: _____

List any serious infectious diseases your child has had during the past twelve months: _____

List any routine or "as needed" medications taken by your child:

_____	_____	_____	_____
(drug)	(dose)	(time)	(how given)

Which of the medications previously listed will be given during school hours (*please complete a **Release to Dispense Medication***)? _____

Check any of the following that apply to your child:

- Glasses Contacts Orthodontics Hearing device

Date: _____

Signature of Parent or Legal Guardian