Concord Christian Academy

STUDENT HEALTH FORM

The Student Health Form must be submitted annually for all Concord Christian Academy students. Please update the information below and select the save button to submit your answers.

Full Name: _____ _____ _____ DOB: _____ Height: _____ Weight: _____

Date of last physical: _____

**A copy must be provided to the Health Office upon admission, followed by every 13 months for athletes and every other year for non-athletes.*

Up-to-date on immunizations? ○ Yes ◉ No

**A copy of immunizations or an exemption form is required upon admission and updated as needed.*

Date of last concussion testing (if applicable): _____

Physician and Insurance

Doctor: _____ Ins. Company: _____

Doctor Phone: _____ Policy Number: _____

Dentist: _____ Group Number: _____

Dentist Phone: _____

Preferred Hospital: _____

Permission to treat ○ Yes ◉ No

I hereby grant permission to Concord Christian Academy to administer First Aid if necessary, and secure proper emergency treatment for my child, in the event a parent or legal guardian cannot be contacted.

Ears, Eyes, Nose & Throat

○ Yes	◉ No	Vision Problems	○ Yes	◉ No	Hearing Loss
○ Yes	◉ No	Tympanotomy (ear) tubes	○ Yes	◉ No	Frequent ear infections
○ Yes	◉ No	Frequent nose bleeds	○ Yes	◉ No	Frequent strep throat infections
○ Yes	◉ No	Glasses/Contacts			

If you marked yes to a condition above, please explain. _____

Skin

○ Yes	◉ No	Problems with rashes	○ Yes	◉ No	Eczema
○ Yes	◉ No	Sensitive skin			

If you marked yes to a condition above, please explain.

Allergies

- ○ Yes ◉ No — No Known Allergies
- ○ Yes ◉ No — Medication, if yes:
- ○ Yes ◉ No — Food, if yes:
- ○ Yes ◉ No — Animals, if yes, symptoms:
- ○ Yes ◉ No — Dyes or soaps, if yes:
- ○ Yes ◉ No — Seasonal, if yes symptoms:
- ○ Yes ◉ No — Bug bites, if yes:

○ Yes ◉ No — **Emergency Action Plan for allergies**

*****Two Epipens must be provided in the original pharmacy container and submitted with an Emergency Action Plan. EpiPens will need to be replaced when they expire.***

- ○ Yes ◉ No — Student will carry own EpiPen and has been trained to use it correctly if needed.
- ○ Yes ◉ No — EpiPen will be provided to keep in the Health Office if needed.

If you marked yes to a condition above, please explain.

Gastrointestinal & Urinary

- ○ Yes ◉ No — Poor Appetite/Picky Eater
- ○ Yes ◉ No — Frequent stomach aches
- ○ Yes ◉ No — Problem with kidneys
- ○ Yes ◉ No — Constipation, how often?
- ○ Yes ◉ No — Diarrhea, how often?
- ○ Yes ◉ No — Dietary Restrictions, if yes please specify
- ○ Yes ◉ No — Urinary incontinence (wets self)
- ○ Yes ◉ No — Fecal incontinence (soils self)

If you marked yes to a condition above, please explain.

Other Conditions & Illnesses

- ○ Yes ◉ No — Chicken pox - if yes, date of illness:
- ○ Yes ◉ No — Broken bones - if yes, please specify:
- ○ Yes ◉ No — Surgery - if yes, provide name and date:
- ○ Yes ◉ No — Overnight hospitalizations - if yes, why?

If you marked yes to a condition above, please explain.

General Health

Would you say your child's health is?

Yes ◉ No Does your child have Asthma?

Yes ◉ No *If yes, does the student have an Asthma Action Plan:

Yes ◉ No *Do you give Permission for your child to carry an Albuterol inhaler?

Yes ◉ No Does your child have Diabetes?

**If yes, Insulin Pump: Yes ◉ No CGM: Yes ◉ No

Has your doctor or health care provider ever told you that your child had any of the following?

Yes ◉ No	Learning Disability	Yes ◉ No	Depression/Anxiety
Yes ◉ No	Heart Murmur	Yes ◉ No	Activity Limitations
Yes ◉ No	Seizures	Yes ◉ No	ADHD
Yes ◉ No	Bleeding Disorder	Yes ◉ No	Blackouts/Fainting
Yes ◉ No	Cerebral Palsy	Yes ◉ No	Concussion
Yes ◉ No	Congenital Heart Disease	Yes ◉ No	Processing Difficulties

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Yes ◉ No Has your child's behavior ever been assessed?

Does your child have:

IEP Yes ◉ No

ISP Yes ◉ No

504 Yes ◉ No

IHP Yes ◉ No

Behavioral Plan Yes ◉ No

Other concerns or comments:

If you marked yes to a condition above, please explain.

Medications

OVER THE COUNTER MEDICATION ADMINISTRATION/PERMISSION TO TREAT FORM
According to the NH Code of Administrative Rules: Education, ED 311.02 School Health Services:
Non-prescription medication shall be given only with the written request and permission of the parent and/or guardian.

Please select yes or no for each authorized medication.
No medication will be administered without parental permission.

Yes ◉ No	Acetaminophen (Tylenol)	Yes ◉ No	Ibuprofen
Yes ◉ No	Benadryl liquid	Yes ◉ No	1% Hydrocortisone Cream
Yes ◉ No	Benadryl Cooling Gel	Yes ◉ No	Calamine Lotion
Yes ◉ No	Triple Antibiotic Ointment	Yes ◉ No	Orajel
Yes ◉ No	Antacids (TUMS)	Yes ◉ No	Cough drops
Yes ◉ No	Lubricant Eye Drops		

Yes ◉ No CCA has my permission to administer over the counter medications to my child, that are provided by CCA

Yes ◉ No CCA has my permission to administer over the counter medications to my child, that are provided from hc

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Is your child currently taking any medications? ○ Yes ◉ No (If no, may skip to parent/guardian signature)

If yes, please list medications and reasons

Will your child require medications to be administered during the day while at school? ○ Yes ◉ No

ADMINISTRATION OF PRESCRIPTION MEDICATIONS AT SCHOOL

According to the NH Code of Administrative Rules: Education, Ed311.02 School Health Services, in order for prescription medications to be given to a student at school, the following is required:

- Permission provided by the parent or legal guardian, and
- An ORIGINAL pharmacy sticker -**OR** - Administration of Prescription Medication-Physician's Medication Statement Form completed by the prescribing physician, nurse practitioner, or physician assistant.

Parent/guardian or parent/guardian-designated-responsible-adult shall deliver all prescription medication to be administered by school personnel to the school designee. The prescription medication shall be in a pharmacy or manufacturer labeled container. No more than a 30-school day supply of the prescription for a student shall be stored at the school.

I hereby give my permission and request that _____ be assisted by the Concord Christian Academy school designee to receive the prescribed medication during school hours as directed and agree that we will not hold liable any member of the school staff who is directed by us (the parents/guardians) and the School Director to assist our child in taking said medication.

1.) Medication:	Medication	Dose	Time or any important information
2.) Medication:	Medication	Dose	Time or any important information
3.) Medication:	Medication	Dose	Time or any important information

Parent/Guardian Signature

Is there anything you would like to discuss with the school nurse? ○ Yes ◉ No

Parent/Guardian Signature

Date

Thank you for completing the annual Student Health Form. In order to submit your answers, you must select the save button.

Save