CAPE CHRISTIAN SCHOOL
STUDENT HEALTH SURVEY
2016-2017

This form must be completed and signed for all CCS students **(one per child)**.

Student Name: _____ **Grade in 2016-2017** _____
(Please print)

A.D.H.D./A.D.D. ❒ Yes ❒ No Is your child currently on medication? ❒ Yes ❒ No

Asthma: Dr. Diagnosed? ❒ Yes ❒ No Wheezing/coughing past 12 months? ❒ Yes ❒ No After active playing? ❒Yes ❒ No

Allergies: ❒ Yes ❒ No Seasonal? ❒ Yes ❒ No Drug or food allergy (list specifics and reactions)? _____

_____

Bladder/Bowel Problems (describe): _____

_____

Diabetes: ❒ Yes ❒ No Diet Restrictions ❒ Yes ❒ No On Insulin? ❒ Yes ❒ No

Hearing Problems: ❒ Yes ❒ No Hearing aid worn? ❒ Yes ❒ No Frequent ear infections? ❒ Yes ❒ No

Has Ear Tube(s): ❒ Yes ❒ No Date of surgery: _____

Heart Problems/Heart Murmur: ❒ Yes ❒ No Activity restrictions? ❒Yes ❒No Date & results of last evaluation: _____

Scoliosis: ❒ Yes ❒ No Current therapy (if any)? _____ Any activity restrictions? ❒Yes ❒ No

Seizures ❒ Yes ❒ No Date and description of most recent episode? _____

_____

Social/Emotional/Mental Health (describe): _____

Vision Concerns: ❒ Yes ❒ No Glasses full time? ❒ Yes ❒ No Contacts? ❒ Yes ❒ No Glasses lost/broken? ❒ Yes ❒ No

Date of last eye examination _____

Recent Surgeries/Hospitalizations: _____

Emergencies: Does your child have a health concern that could result in an emergency? ❒ Yes ❒ No

If yes, describe: _____

Other Health Concerns: ❒ Yes ❒ No If yes, explain: _____

Are there Any Restrictions of Your Child's Activities? ❒ Yes ❒ No

If yes, explain: _____

_____

_____

The school does not assume responsibility for any situation that may occur as a result of false information or lack of information. This health information may be shared with school staff as needed. If you do not want this health information shared, please contact the school office at Cape Christian School. ******For the protection of our students, dispensing of any medications, including over-the-counter, non-prescription drugs, IS PROHIBITED without proper authorization from both a parent and physician, indicating the necessity of administering medication during school hours.****To authorize, please complete the Authorization for Administration of Medication at School form.**

Parent/Guardian Signature: _____ **Date:** _____

Print Parent/Guardian Name: _____