Student Health Information
Concordia Academy

Please complete all questions.

Student's Name _____ Birth Date _____ Grade _____

Please check past and current concerns applicable to this child. If current describe below:

☐ ADD/ADHD	☐ Chronic bowel problems/concerns	☐ Head injury (describe below)
☐ Allergies (mild)* (including foods)	☐ Cystic Fibrosis	☐ Heart/circulation impairment
☐ Allergies (severe)* (including foods)	☐ Depression	☐ Seizures
☐ Anemia	☐ Diabetes	☐ Social problems/concerns
☐ Asthma mild (no meds) **	☐ Eczema	☐ Substance abuse (alcohol, drugs)
☐ Asthma (requires meds) **	☐ Emotional problems/concerns	☐ Suicide attempt
☐ Behavior problems/concerns	☐ Ear/hearing concerns	☐ Tics (describe below)
☐ Birth or congenital malformation	☐ Eye/poor vision problems/concerns	☐ Urinary tract infections
☐ Birth marks	☐ Frequent headaches	☐ Sleep problems/concerns
☐ Bone/joint disease or injury	☐ Frequent skin infections	☐ Wears glasses
☐ Cancer	☐ Frequent sore throats	☐ Weight/eating disorder
☐ Chicken Pox Mo/yr:_____		

Does your child have any other health (physical/emotional) concerns you want to discuss with the school nurse? YES ☐ NO ☐

Please describe your child's current health concerns. Do you have other comments or concerns about this child's health, development, mental health, behavior, family, or home life that would be helpful for the school to be aware of? Injury in the past 12 months?

_____

_____

***Allergies – Please list allergies and describe reaction to:**

Has an allergy to:	Reaction to:

****Asthma – Please describe how severe and what are the triggers:**

_____

_____

What medication(s) does your child take?

Name of Medication	Dose / Time	Taken at Home or School

Please indicate your child's doctor or clinic and telephone number:

Doctor/Clinic: _____ Telephone: _____

Parent/Guardian Signature: _____

Relationship to Child: _____ Date: _____