Cornerstone Christian Academy

129 Route 28, Mountainside • Ossipee, NH 03864

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Student Health Questionnaire

for School Year 20___/___

Student Name: ____________________________________DOB____/____/____ Male / Female

Does your child have any of the following conditions?

_____ Glasses/Contacts	_____ Asthma	_____ Seizure Disorder
_____ Ear/Eye Problems	_____ ADD/ADHD	_____ Dietary Restrictions
_____ Braces/Retainers	_____ Diabetes	_____ Restrictions on exercise*
_____ Chronic Illness*	_____ Headache/Migraine	_____ Other*

* Explanations: ____

____

Does your child have ALLERGIES? (please specify) ___________________________________

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____

Does your child take any medications daily?

Please list: Name__________________________________Time Taken________________

Name__________________________________Time Taken________________

The school will only administer medications that must be taken during school hours.
To ensure the health and safety of your child, pertinent medical and/or custody information will be held confidential and only be shared with appropriate school personnel.

Signature of Parent/Guardian______________________________________Date___________

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