



Cornerstone Christian Academy

129 Route 28, Mountainside • Ossipee, NH 03864

TEL: 603.539.8636 • EMAIL: info@cornerstoneca.net

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 | _____ Allergies* |
| _____ Chronic Illness* | _____ Headache/Migraine | _____ Other* |
| _____ Restrictions on exercise* | | |

* Explanations: _____

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 _____

Signature of Parent/Guardian _____ Date _____