Central Christian School Health History / ER Medical Card

5801 Schwartz Road Fort Wayne IN 46835
260-493-0193 www.centralchristianfortwayne.org

Parent/Guardian: Please complete one Health History/ER Medical Card for EACH of your students at CCS.

Student Name ____________ Phone ____________ Date of Birth ____________ Grade ____________

Mother/Guardian ____________ Occupation & Work Phone ____________ Cell Phone ____________ Email ____________

Father/Guardian ____________ Occupation & Work Phone ____________ Cell Phone ____________ Email ____________

Doctor's Name/Practice ____________ Doctor Phone Number ____________ Hospital Preference ____________

Complete the checklist by indicating any of the conditions, past or present. Include a separate sheet if necessary.

	YES	NO	DATE	Additional Information
Allergies – Seasonal/Animal				Seasonal or Animal Life Threatening? Epi Pen Needed?
Allergies – Food				Life Threatening or Intolerance? Epi Pen Needed?
Allergies – Insect Bites/Stings				Life Threatening? Epi Pen Needed?
Allergies – Medications				Action Needed:
ADD/ADHD				Medication:
Anemia				
Arthritis				Type:
Asthma				Is an ER Inhaler required? (Explain)
Back/Neck Injury-Condition				Explain:
Bladder/Kidney Trouble				Explain:
Blood/Clotting Disorder				Hemophilia/Other
Cancer/Leukemia				
Diabetes				Type 1 or Type 2
Diet Restrictions				
Headaches – Chronic				
Hearing Loss				Wear hearing aide?
Heart Condition				Rheumatic Fever, Murmur as infant or Recent? Explain.
Lead Poisoning				
Lung Disease/Tuberculosis				
Eating Disorder				
Psychological/Psychiatric				Medication:
Seizures				Explain
Vision				Glasses or Contacts
Please List ALL Other Concerns not already discussed.				

If any health items will impact your child's routine at school, please give details:

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List any medications (prescribed and over the counter) that is taken daily by your student.

Medication Name	**Dosage**	**Frequency**	**Reason**
______________________________	______________________	_____________________	____________________________
______________________________	______________________	_____________________	____________________________
______________________________	______________________	_____________________	____________________________

Most medication can be taken at home. If this student is required by a physician to take medication during school hours, please indicate by filling in the information below.

Doctor's Name & Number	Medication	Condition
____	______________________	_____________________
____	______________________	_____________________
____	______________________	_____________________

Below is a list of common medications for pain or upset stomach. Please indicate the medications your student may take without the need to call for verbal permission:

Medication Name	**Yes**	**No**
Children's Tylenol or Generic	_________________________	__________________________
Children's Advil or Generic	_________________________	__________________________
Tums or Generic	_________________________	__________________________
Children's Pepto-Bismol or Generic	_________________________	__________________________
Adult Strength Tylenol or Generic	_________________________	__________________________
Adult Strength Advil or Generic	_________________________	__________________________
Hall's Cough drops	_________________________	__________________________
Peppermint Hard Candy (to settle stomach)	_________________________	__________________________
Anti-itch cream	_________________________	__________________________
Triple antibiotic cream	_________________________	__________________________
Children's Pepto	_________________________	__________________________

Any students with Asthma, Diabetes, Seizures, Food Allergies, Insect Sting Allergies, Cancer, Hemophilia and/or other serious health conditions should have an individual plan stating specific needs we must be aware of to best care for your student.

In case of an emergency involving your child, it is our policy to render first aid treatment while contacting the parent/guardian for further instructions. After reasonable efforts to reach the parents without success will we call a doctor, and only in extreme cases will your child be taken to a medical care facility or hospital or 911 contacted. To ensure the care of my child, I have read and agree that pertinent health information may be provided to appropriate school staff. I agree that the school may consult with my child's family physician(s) about the above medical condition(s). I agree to alert the school, including my child's teacher, in writing of any changes in medications and/or health status of my child. I will furnish the school with a current telephone number and address.

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Parent/Guardian Signature   Date