| birth Date:   | CENTRAL CHRISTIAN ACADEMY<br>5503 N Hiawassee Rd Orlando, FL 32818 • (407) 930-6364 Phone<br>MEDICAL INFORMATION<br>2022-2023 |   |  |
|---|---|---|--|
| Theck if the student has had any of the following. Give dates of any positive answer.       German Measles         Polio       Jaundice         Practures       Mumps         Rheumatic Fever       Kidney Infection         Malaria       Concussion/Head Injury         Other       Other         Asthma       Abdominal Pains         "heck if the student has had any of the following. Please explain any positive answers.       Constipation         Bar Trouble       Hearing Loss/Defect       Bladder Problem         Glasses       Epilepsy       Tonsillitis         Heart Trouble       Contact Lenses       Epilepsy       Tonsillitis         Diabetes       Indigestion       Hernia       Tonsillitis         Sexplanations: | Name:   |   |  |
| Check if the student has had any of the following. Please explain any positive answers.   | Check if the student has had any of the following. Give dates of aPolioJaundice   | any positive answer.<br>Whooping Cough<br>Rheumatic Fever<br>Scarlet Fever<br>Measles<br>Kidney Infection |  |
| AsthmaAbdominal PainsHay FeverConstipationGlassesGlassesGlassesGlassesGlassesGlassesGlassesGlasses  | Explanations:   |   |  |
| Is the student on any medications?       YesNo         pecify   | Asthma Abdominal Pains<br>Ear Trouble Hearing Loss/Defect<br>Heart Trouble Contact Lenses                                     | Hay Fever Constipation<br>Bladder Problem Glasses<br>Epilepsy Tonsillitis                                 |  |
| pecify  | Explanations:   |   |  |
| schedule?YesNo f yes, please describe:YesNo f yes, please describe:YesNo F yes, please describe;YesNo F yes, please describe;YesNo f yes, when and how long a periodYesNo f yes, when and how long a periodYesNo  | 3. Is the student on any medications?YesNo<br>Specify   |   |  |
| <ul> <li>Has your child had any operations? Yes</li> <li>No</li> <li>f yes, please describe:</li> <li>Does your child have any allergies? Yes No</li> <li>F yes, please describe; No</li> <li>Has your child ever been treated for any nervous, mental, or emotional disorder? Yes No</li> <li>f yes, when and how long a period</li> </ul>   | schedule?   |   |  |
| _No f yes, please describe:  Does your child have any allergies?YesNo F yes, please describe;   |   |   |  |
| . Does your child have any allergies?YesNo<br>F yes, please describe;<br>. Has your child ever been treated for any nervous, mental, or emotional disorder?YesNo<br>f yes, when and how long a period   | No  |   |  |
| F yes, please describe;   | If yes, please describe:  |   |  |
|   | 7. Has your child ever been treated for any nervous, mental, or em  |   |  |
| Is there any other medical information about your child that you think we should have?  | 8. Is there any other medical information about your child that yo  |   |  |

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