COMMUNITY CHRISTIAN SCHOOL

PO Box 780 • 1719 S Mt Olive St • Siloam Springs, AR 72761
PHONE: (479) 373-1049
EMAIL: info@ccs-siloam.com • WEBSITE: www.ccs-kings.com

Health Form

Student's Name_____ Date ____/____/_____

Last First Middle

Does your child have any of the following?

____A.D.D.	____A.D.H.D	____Allergies (foods, insects, medications, etc,)
____Asthma	____Been Suicidal	____Bleeding Disorder
____Bronchitis	____Chicken Pox	____Depression
____Disabilities	____Dizziness	____Head Injury
____Fainting	____Hearing Loss	____Headaches
____Hypoglycemia	____Hyperactivity	____Injuries
____Hepatitis	____Kidney Disease	____Muscular Disorders
____Nose Bleeds	____Seizures/Convulsions	____Stroke
____Ulcers	____Vision Loss	____Other

Please explain thoroughly any checked above: _____

_____

_____

Emergency Contact _____ Emergency Phone _____-_____-_____

Relationship _____ Is applicant taking medication on a regular basis?
Yes ☐ No ☐

Name of medication_____ Reason _____

Name of medication_____ Reason _____

Family Doctor _____ Phone _____-_____-_____

Hospital Choice _____ Phone _____-_____-_____

If no one can be reached at the above numbers, by signing below I hereby give permission for a school official to call 911 or take my child to a physician or hospital for treatment. I understand that this is for emergencies only and I will be responsible for any charges that may occur.

_____ _____/_____/_____

Signature of Parent/Guardian Date