COMMUNITY UNIT SCHOOL DISTRICT #20
HEALTH INFORMATION

Student Name:_____ DOB:_____ Grade:_____ Date: _____

	Circle Yes or No	Comment
Allergies? (food, drug, insect, other) (All food allergies must be doctor diagnosed and note on file at school)	Yes No	To what? Type of reaction?
Taking Medication? (All medication given at school must have a Physician medication order completed each year and on file at the school-includes prescription, over the counter medications and inhalers)	Yes No	List all medications:
Diagnosis of asthma:	Yes No	Severity? Symptoms?
Eye/Vision Problems? Date of last exam:_____	Yes No	Glasses or Contacts
Ear/Hearing Problems?	Yes No	Explain:
Blood Disorders?	Yes No	Explain:
Diabetes?	Yes No	Insulin?
Seizures? Medication for seizure?:_____	Yes No	Date of last seizure:_____ What are the seizures like?_____
Heart Problems/Shortness of Breath?	Yes No	Explain:
Heart Murmur/High Blood Pressure	Yes No	Explain:
Bone/Joint Problems/Scoliosis?	Yes No	Explain:
Serious Injury or Illness?	Yes No	Explain:
Ever been diagnosed with a concussion?	Yes No	Explain:
Other Medical Concerns?	Yes No	Explain:

Information above may be shared with appropriate personnel for health and educational purposes only.

Parent/Guardian Signature_____Date_____

1-2018