Carterville Community Unit School District #5 School Year: _____

HEALTH INFORMATION FORM Grade: _____

Name: _____ Date of Birth: _____

Doctor's Name: _____ Doctor's Phone #: _____

Check the box(s) if your child has a history or any medical problems or illnesses:

☐ **No history of medical problems/illnesses**
☐ **Asthma….Inhaler** ☐ **None** ☐ **Self Carry** ☐ **Kept at school, Triggers?** _____
☐ **Seizures…** How long since last seizure? _____
☐ **Heart Conditions…** Describe: _____
☐ **Diabetes…** Takes insulin? ☐Yes ☐No
☐ **Stomach problems**
☐ **Migraine Headaches**
☐ **Congenital Illness…** Describe: _____
☐ **Hearing Problems…** Hearing aid? ☐Yes ☐No
☐ **Any Physical Restrictions…** Describe: _____
☐ **Allergies (Please describe reaction)**
- ☐ **Food:** _____ Difficulty breathing? ☐ Yes ☐No
- ☐ **Insect Stings:** _____ Difficulty breathing? ☐ Yes ☐No
- ☐ **Animals:** _____ Difficulty breathing? ☐ Yes ☐No
- ☐ **Medication:** _____ Difficulty breathing? ☐ Yes ☐No
- ☐ **Other:** _____ Difficulty breathing? ☐ Yes ☐No

Comments: _____

Other medical concerns: _____

Medication: (please list below) **None**

Name of Medication	Reason for taking	Home	School	Emergency Only
1.	**1.**	☐	☐	☐
2.	**2.**	☐	☐	☐
3.	**3.**	☐	☐	☐

If your child has a serious illness that requires emergency medication, it is important to keep the medication at school. The School Medication Authorization Form must be completed by the parent/guardian as well as the Doctor. These are available in the office.

I consent that the information on this form may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature: _____ **Date:** _____