

Gallatin County Community Unit School District No. 7

Dr. Judy Kaegi, Superintendent
5175 Highway 13
Junction, IL 62954
(618) 272-3821

Student's Name _____ Date of Birth _____ Grade _____

Doctor's Name _____ Doctor's phone and fax # _____

Check if your child has no history of medical problems, illnesses, or allergies.

Check where appropriate

___ Asthma Triggered by _____ Uses inhaler ___ Yes ___ No Uses nebulizer ___ Yes ___ No

___ Seizures Type/Describe _____ Last seizure _____

___ Heart Condition Describe _____

___ Diabetes Takes Insulin ___ Yes ___ No

___ Stomach Problems Describe _____

___ Migraine Headaches Triggered by _____

___ Frequent Strep Throat

___ Frequent Ear Infections History of tubes ___ Yes ___ No

___ Visual Problems Glasses ___ Contacts ___ Surgery ___

___ Hearing Problems Hearing Aid ___ Yes ___ No

___ Speech Problems

___ Braces/ Dental Appliance

___ Congenital Illness Describe _____

___ Any physical Restrictions Describe _____

___ Autism _____

___ Behavioral Problems _____

___ **Allergies Uses Epipen** _____

___ Food Types of Food _____

___ Insect Stings Types of Insects _____

___ Animal Types of Animals _____

___ Seasonal _____

___ Drug Allergies List _____

___ Other List _____

Describe Reaction(s) _____

___ Other medical concerns/ conditions _____

Medication(s) child is currently taking

Child takes medication at:

Name of medication	Reason taking medication	Home	School	Emergency	As Needed
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1. _____	1. _____	_____	_____	_____	_____
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2. _____	2. _____	_____	_____	_____	_____
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3. _____	3. _____	_____	_____	_____	_____
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4. _____	4. _____	_____	_____	_____	_____
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If your child has a serious illness/allergy that requires emergency medication, it is important to keep the medication at school. A medical Authorization Form must be completed by the parent/guardian and the doctor-forms are available in the school nurse's office. I consent that information on this form may be shared with appropriate personnel for health and education purposes. I also consent that the school nurse may consult with the child's physician, optometrist/ophthalmologist or dentist regarding appointments, examinations, medical conditions, immunizations and/or medications when deemed necessary.

Parent/Guardian signature _____ **Date** _____