CARMI-WHITE COUNTY C.U.S.D. #5
ANNUAL HEALTH INFORMATION FORM*
***Form Must Be Completed Annually for Each Student**

Student's Last Name _____ First Name _____ Date of Birth _____ Grade Level _____

Physician's Name _____

Check (√) the box if your child has no history of medical problems, illness, or allergies and complete signature below.
☐ No history of medical problems, illness or allergies. Immunization Exempt ☐Yes ☐No May share with IDPH ☐Yes ☐No

Check (√) the box(es) if your child has a history of any medical problems &/or illness.

☐Asthma: Triggered by:_____ Uses inhaler ☐Yes ☐No Uses Nebulizer ☐Yes ☐No
Severity: ☐Mild/Intermitten ☐Moderate ☐Severe

☐Seizures: Date of last:_____ Has your child been prescribed Diastat? ☐Yes ☐No
Type: ☐Grand Mal ☐Petit Mal ☐Partial Complex

☐Diabetes: Age Diagnosed:_____ Requires Carb Counting ☐Yes ☐No Takes Insulin ☐Yes ☐No

A plan of care must be in place – contact the district nurse.

☐Frequent Ear Infection: Tubes ☐Yes ☐No
☐Hearing Problems: Hearing Aids ☐Yes ☐No
☐Vision Problems: Wears Glasses ☐Yes ☐No Wears Contacts ☐Yes ☐No
☐Skin Disorders: ☐Eczema ☐Psoriasis ☐Other:_____
☐Has your child had chicken pox: ☐Yes ☐No

☐ADD/ADHD ☐In counseling: List physician's name and diagnosis_____
☐Anxiety/Panic/Emotional Disorder ☐Cerebral Palsy ☐Speech Problems
☐Autism / Aspergers ☐Frequent Strep Throat ☐Stomach / Bowel Disorders
☐Bleeding Disorders ☐Headaches / Migraines ☐Other:_____
☐Braces / Dental Appliances ☐Kidney / Urinary Disorders

Check (√) the box(es) if your child has a history of any allergies.

Allergy:	Please List:	Reaction:		
☐Latex	_____	☐Difficulty Breathing	☐Rash	☐Other:_____
☐Medication	_____	☐Difficulty Breathing	☐Rash	☐Other:_____
☐Foods	_____	☐Difficulty Breathing	☐Rash	☐Other:_____
☐Insect Stings	_____	☐Difficulty Breathing	☐Rash	☐Other:_____
☐Animals	_____	☐Difficulty Breathing	☐Rash	☐Other:_____
☐Other	_____	☐Difficulty Breathing	☐Rash	☐Other:_____

Has your child been prescribed an EpiPen: ☐Yes ☐No Food Allergy? ☐Yes ☐No List substitute_____

A note is required from the doctor for any allergy restrictions at school.

Please list any medication your child is currently taking.

Name of Medication:	Reason for Taking:	Home	School	Emergency
1. _____	1. _____	☐	☐	☐
2. _____	2. _____	☐	☐	☐
3. _____	3. _____	☐	☐	☐

If your child has a serious illness/allergy that requires medication, it is important to keep the medication at school.
A medication authorization form must be completed by the parent/guardian and doctor to be kept on file at school.

I consent that information on this form may be shared with appropriate school personnel for health and educational purposes. The school nurse may consult with your child's physician regarding medical conditions and/or medications when necessary.

Parent/Guardian Signature: _____ Date:_____

Phone #:_____ 01/22