Somonauk Community Unit School District #432
Student Health History

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office.

Student's Name:	Birth Date:
Male □ Female □	
Address:	
Home Phone:	Emergency Phone:
School:	Grade: Teacher:
Daily Medications (list names and dosage): *Include those taken at home. If taken at school, School Medication Authorization Form must be completed by physician and be on file at school.*	
Allergies-Life Threatening: □ Yes □ No	Please list:
Allergies-Other: □ Yes □ No	Please list:
Asthma: □ Yes □ No	Please explain:
Attention Deficit Disorder: □ Yes □ No	□ With or □ Without Hyperactivity
Blood Disorder: □ Yes □ No	Please explain:
Concussion/History of: □ Yes □ No	Please explain:
Diabetes: □ Yes □ No	Please explain:
Ear/Hearing Problems: □ Yes □ No	Please explain:
Eye/Vision Problems: □ Yes □ No	Please explain:
Glasses/Contacts: □ Yes □ No	Glasses, contacts or both:
Heart Problems: □ Yes □ No	Please explain list:
Headaches/Migraine: □ Yes □ No	Please explain:
Hospitalizations: □ Yes □ No	Please list and give age:
Mental Health Concerns: □ Yes □ No	Please explain:
Musculoskeletal Problems: □ Yes □ No	Please explain:
Neurological Problems: □ Yes □ No	Please explain:
Physical Restrictions: □ Yes □ No	Please describe:
Seizures: □ Yes □ No	Please explain:
Serious Injuries: □ Yes □ No	Please list and give age:
Surgery: □ Yes □ No	Please list and give age:
Other Medical Information or concerns: _____ _____ _____	

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

_____ _____
Parent/Guardian printed name Parent/Guardian printed name

_____ _____
Parent/Guardian signature Date Parent/Guardian signature Date

- PLEASE COMPLETE INFORMATION ON REVERSE SIDE -

Student's Name:	Birth date:

Physician's Printed Name:
Physician Office Address:
Office Phone: Emergency Phone:
Dentist's Printed Name:
Dentist Office Address:
Office Phone: Emergency Phone:

Authorization for Emergency Medical Treatment:

In the event reasonable attempts to contact me at the location(s) listed below are unsuccessful, I, as parent or legal guardian of (name of student) _____ so hereby authorize (1) The treatment by a licensed medical physician of my child/and in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed and (2) the transfer of my child/ward to any hospital reasonably accessible. This release form is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence:

_____ _____

Parent/Guardian printed name Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date Parent/Guardian signature Date

Relationship to student: _____ Relationship to student: _____

Authorization to Release Health Records:

I hereby authorize my child's health care provider to release my child's most recent physical, immunization record, vision and hearing results and medication information to Somonauk Community Unit School District No. 432 for completion of the student health record. This authorization is valid for one year.

_____ _____

Parent/Guardian printed name Parent/Guardian printed name

_____ _____

Parent/Guardian signature Date Parent/Guardian signature Date

Relationship to student:_____ Relationship to student:_____

- PLEASE COMPETE INFORMATION ON REVERSE SIDE -