STUDENT'S NAME: _____ Date of Birth:_____ Grade:_____

ITASCA SCHOOL DISTRICT 10

ADMINISTRATIVE CENTER
200 N. Maple St
Itasca, IL 60143-1722
(630)773-1232 Fax (630)773-1342

Health Information Questionnaire/Release

***Parent/Legal Guardian*: Please complete the following information about your child's health history. The information is to keep your child's school health record up to date. It is confidential record and remains in the health office. The information may be shared with other school personnel to ensure your child's academic success and/or personal safety. If you have any questions, please contact the Nurse at your child's school.**

Does your child have:

Seizures/Seizure Disorder…Yes_____ No_____ Type: _____

Diabetes……Yes_____ No_____ Type: _____

Cancer……Yes_____ No_____ Type: _____

Asthma……...Yes_____ No_____ (**If Yes,** please fill out **Parent Authorization Form for Inhalers** and have medical provider fill out **Asthma Action Plan**. (*Forms available online and in school health office*)

Other serious illness/chronic conditions not listed:_____

ALLERGIES: Does your child have any allergies to the following?

Food……Yes_____ No_____Type_____Reaction_____

Plants…… Yes_____ No_____Type_____Reaction_____

Bees/Insects…Yes_____ No_____Type_____Reaction_____

Drugs……Yes_____ No_____Type_____Reaction_____

Animals…….Yes_____ No_____Type_____Reaction_____

Others not listed- Please specify_____

If your child needs Emergency Medications for allergies, please complete Allergy Action Plan, Individual Healthcare Plan and the Itasca #10 Medication Authorization Form (One form per medication. Forms available online and in school health office).

List ALL Prescription Medications your child is taking, dosages and time of day:

1._____3._____

2._____4._____

If your child needs to take medication at school, please complete the Itasca #10 Medication Authorization Form. (This includes over-the-counter medications, including cough drops, etc.)

Does your child wear glasses and/or contacts? Yes or No

[If yes] Date of last Eye Exam:_____ Results: _____

Does your child have any hearing difficulty? Yes or No

Does your child wear hearing aids? Yes or No

Is there anything about your child's health, physical or emotional background that you would like the school health staff and teacher to know?_____

_____

If emergency treatment is necessary, I hereby give permission for my child to be taken to the nearest doctor or hospital and agree to pay all fees in connection with such treatment or service not covered by insurance.

_____

Signature of Parent/Guardian Printed Name Date