

**Wood Dale School District #7  
Student Health History  
and  
Emergency Medical Information**

Student's Name:		School:
Parent/Guardian Name:	Grade/Teacher:	Date of Birth:
Home Phone:	Work Phone:	Cell Phone:

In an effort to provide optimum health services for your child and to keep your child's school health record complete and up to date, we ask for your cooperation in providing the following information.

**The information contained on this form is confidential and will only be shared with related school or emergency medical personnel, as deemed necessary for the safety of your child.**

**Does your child have:**

Allergies*** <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is your child allergic to:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>***If your child has a food allergy, please complete the information on the back of this form</b>		
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe trigger(s) and/or symptoms:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No		Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach care plan:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe type and treatment:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:	Is medication needed at school: <input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child wear glasses / contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	When was your child's last eye examination?
Hearing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:	Does your child wear hearing aid(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, describe:	List restrictions, if any:

Other Health Concerns: (Please describe)

Is your child taking any medications regularly:  Yes  No If yes, please list:

<u>Medication</u>	<u>Medication</u>	<u>Medication</u>
Name: _____	Name: _____	Name: _____
Dosage: _____	Dosage: _____	Dosage: _____
Time: _____	Time: _____	Time: _____
Condition/reason for medication: _____	Condition/reason for medication: _____	Condition/reason for medication: _____
<input type="checkbox"/> Will Take At Home <input type="checkbox"/> Will Take At School	<input type="checkbox"/> Will Take At Home <input type="checkbox"/> Will Take At School	<input type="checkbox"/> Will Take At Home <input type="checkbox"/> Will Take At School

Any child requiring medication at school will need to provide a completed Wood Dale School District #7 ~ School Medication Permission Form (which includes parent signature and contact information, as well as the doctor's instructions and signature)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete and return this form to your child's school.**