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

Medication	Medication	Medication
Name: _____	Name: _____	Name: _____
Dosage: _____	Dosage: _____	Dosage: _____
Time: _____	Time: _____	Time: _____
Condition/reason for medication: _____	Condition/reason for medication: _____	Condition/reason for medication: _____
□ Will Take At Home □ Will Take At School	□ Will Take At Home □ Will Take At School	□ Will Take At Home □ 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.

Food Allergy History Form

Name: _____ D.O.B.: _____ Teacher: _____

Allergy to: _____

- Is your child asthmatic? Yes** No **Higher risk for severe reaction • Does your child react to cross-contamination? Yes No
- Does your child react to air-borne contamination? Yes No
- When and how did you first become aware of the allergy?

_____

- When was the last time your child had a reaction?

_____

- Please describe the signs and symptoms of the reaction:

_____

- What type of medical treatment should be provided for your child?
  Epinephrine Antihistamine Other: (please list) _____
- Does your child require an allergen-free eating area? Yes No
- I would like my child's emergency medication kept in the:

School Office Classroom School Office and Classroom

- If the emergency medication is kept in the classroom, the medication should be transported by school personnel wherever my child travels to within the school: Yes No
- I would like to accompany my child on field trips: Yes No
- Students in the classroom should be encouraged to wash their hands upon arrival to school and after eating lunch: Yes No
- I will provide a shelf-stable allergen free snack that will be available in the classroom, if needed: Yes No

Please list other accommodations needed at school or other concerns we should be aware of:

_____

_____

Parent Signature: _____ Date: _____