WEST CARROLL SCHOOL DISTRICT #314

Health Information Form

Child's Name_____ **Child's Birthdate**_____ **Age**____ **Grade**____

Who is filling out this form?

☐ Mother ☐ Father Your Name (Do they live with you??):_____

☐ Other (please explain relationship to child)_____

Doctor's name: _____ ***Phone number:***_____

MEDICAL HISTORY

1. Has your child ever been a **patient in a hospital** (other than a few days after birth)?

☐ No (If no, go to question #2.)

☐ Yes (If yes, explain why and when below.)

My child was in the hospital because:	**When**
Example: Bike accident	5 years old

2. Is your child taking any **prescription medicines**?

☐ Yes - Please list the child's medicines below OR

☐ No. My child does not take any prescription medicines. (If no, go to question #3)

Does your child use an inhaler or breathing treatments? ☐ Yes ☐ No. If **YES**, please list medicine below and see the Medication Administration Policy in the Handbook.

Name of medicine	**Amount / size of pill**	**How many pills or doses does your child take at**
Example: Dexadrine	10 mg	1 morning ____noon ____dinner 1 bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed
		____morning ____noon ____dinner ____bed

3. What **over-the-counter medicines** does your child take regularly?

☐ Vitamins

☐ Herbal medicine (please list) _____

☐ Other (please list) _____

☐ None, my child does not take any over-the-counter medicines regularly.

Please Turn Page Over

4. Does your child have any **allergic reaction Diagnosed by a Physician** from any of the following?

☐ (Check all that apply.) Outside or Indoor allergies, (for example: hay-fever, grass, pollen, cats …) Please list below

☐ Food Allergies (for example: peanuts, milk, wheat …) Please list below

☐ Insect or Animal Allergies (for example: bees, wasps, cats…) Please list below

☐ Medicine or shots (immunization). Please list below

☐ No, my child has no allergies that I know of.

Does your child have an **Epi-Pen** or **Auvi-Q?** ☐ Yes ☐ No If **YES**, please bring one to school.

My child is allergic to:	**What happens when your child has a reaction?**
Example: amoxicillin	Diarrhea (runny poop)

5. Has your child had any of the following **medical problems or injuries**? (examples in parenthesis) Describe **your child's** problem for each ☒**Yes** on the lines at the end.

Chicken Pox	☐ Yes	☐ No	☐ Don't Know
Surgery	☐ Yes	☐ No	☐ Don't Know
Head Injury or Concussion	☐ Yes	☐ No	☐ Don't Know

Ear infections *(often has them, ear tubes, etc)*	☐ Yes ☐ No
Nose problems *(sinus infections, nose bleeds)*	☐ Yes ☐ No
-Should **wear glasses** to see ☐ far away ☐ read	
Eye problems (*blurry vision, wears glasses, lazy eye)*	☐ Yes ☐ No
Hearing problems *(has trouble sometimes, wears hearing aid)*	☐ Yes ☐ No
Mouth or throat problems *(Strep throat, swallowing problems)*	☐ Yes ☐ No
Constipation *(problems having a bowel movement (BM))*	☐ Yes ☐ No
Problems **peeing** *(bed wetting, pain when peeing)*	☐ Yes ☐ No
Back problems *(crooked back, back pain)*	☐ Yes ☐ No
Muscle and bone problems *(weak muscles, pain in joints)*	☐ Yes ☐ No
Skin problems *(acne, flaking skin, rashes, hives)*	☐ Yes ☐ No
Seizures *(shaking fits or convulsions)*	☐ Yes ☐ No
ADD/ADHD *(problems paying attention, sitting still)*	☐ Yes ☐ No
Breathing problems *(cough, asthma)*	☐ Yes ☐ No
Diabetes: Type 1 or Type 2 Age when diagnosed: Insulin dependent:	

Did you ☒**Yes** for any problems above ***or if your child has any special health needs*** please describe. **Tell us more here:**

_____

_____

_____ _____

Signature of person filling out form Date filled out

******Please Note that if your child has any health changes through-out the school year, call your student's nurse to update their information******