

**Intermediate School District 917
Health Information Form**

School Year _____

Student Name _____ **Date of Birth** _____ / _____ / _____

Parent/Guardian: Please complete the following questions concerning your child's health information. Complete information will allow School Health Services to better provide the attention, assessment and care needed for your child in the school setting. Teamwork between you and Health Services is encouraged and benefits your child. Thank you for your assistance.

Medications (All):	Name	Dose	Times	Reason

Specialized Healthcare Procedures: _____

Allergies to Medication: YES ___ NO ___ If yes, please list _____
Type of Reaction: _____

Allergies (food, pollen, insects, etc): YES ___ NO ___ If yes, please list _____
Type of Reaction: _____

Food Intolerances (no allergic reaction, but difficulty with digestion that may require monitoring diet for): _____

Diet Problems/Restrictions: _____

Please check the following that apply to your child and explain any current (within past three months) problems below:

	PAST	NOW		PAST	NOW
Accidents (serious)	___	___	High Blood Pressure	___	___
Asthma	___	___	Joint & Bone Problems	___	___
Autism	___	___	Kidney Problems	___	___
Blood Disorder	___	___	Menstrual Problems	___	___
Cardiac Disease	___	___	Muscle Problems	___	___
Developmental Delay	___	___	Rheumatic Fever	___	___
Diabetes	___	___	Seizure Disorder	___	___
Ear Conditions/Infections	___	___	Skin Problems	___	___
Eye Conditions	___	___	Speech Problems	___	___
Frequent Colds/Sore Throat	___	___	Stomach Problems	___	___
Illness (serious)	___	___	Surgeries	___	___
Headaches	___	___	Urinary Problems	___	___
Heart Problems	___	___	Other: _____	___	___

PLEASE EXPLAIN ANY CURRENT PROBLEMS: _____



Please complete the following:

Student Name: _____

Hearing Loss YES ___ NO ___
(Right / Left / Both)

Hearing Aids: YES _____ NO _____

Last Hearing Test: ___ / ___ / ___

Comments: _____

Vision Loss YES ___ NO ___
(Right / Left / Both)

Glasses: YES _____ NO _____ Contacts: YES _____ NO _____

Last Eye Exam: ___ / ___ / ___

Comments: _____

Last Physical Exam: ___ / ___ / ___

Clinic: _____

Last Dental Exam: ___ / ___ / ___

Clinic: _____

Specialist Names, if applicable Medical Specialty Phone/Fax Number
(Family physician's contact information already indicated on Student Emergency Contact Form)

1. _____ Phone (_____)
Clinic Name / Address _____ Fax (_____)
2. _____ Phone (_____)
Clinic Name / Address _____ Fax (_____)
3. _____ Phone (_____)
Clinic Name / Address _____ Fax (_____)

Immunization Updates in Past Year: (Must include month, date and year)

Type of Vaccine	1 st Dose	2 nd Dose	3 rd Dose	4 th Dose	5 th Dose
Hib (haemophilus influenzae type b)	___/___/___ (month/date/year)				
DTP (diphtheria, tetanus and pertussis)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)
Polio	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	
Hepatitis B	___/___/___ (month/date/year)	___/___/___ (month/date/year)	___/___/___ (month/date/year)		
MMR	___/___/___ (month/date/year)	___/___/___ (month/date/year)			
Td Booster (shot after their 11 th birthday)	___/___/___ (month/date/year)				
Chicken Pox* (varicella)	___/___/___ (month/date/year)	___/___/___ (month/date/year)	*Date of Illness-MD verified ___/___ (month/year)		

Behavior/Emotional Problems: Please **circle** any problems your child exhibits and explain as needed.

- | | | | |
|--------------------------------|-----------------------------|-------------------------------|----------------------|
| ADD/ADHD | Aggression | Anxiety | Depression |
| Difficulty Communicating Needs | Impulsiveness | Increased Physical Complaints | Repetitive Behaviors |
| School Phobia | Self Injury/Risky Behaviors | Withdrawn Behavior | |

Other: _____

Comments: _____

Parent/Guardian Signature (If completed by another adult, indicate relationship)

_____/_____/_____
Date