

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 15
Palatine, Illinois

HEALTH INFORMATION SURVEY

2007-08

Dear Parents:

To help meet your child's health needs in school, we are asking that you complete the information requested below and return this form to the school. If you have any questions, please call your School Health Office. Thank you for your cooperation.

_____ M F _____
Student's Name Birth Date School 2007-08 Grade Level

THIS FORM MUST BE COMPLETED, SIGNED, AND DATED YEARLY

Does your child wear glasses? Yes No Have a history of hearing problems? Yes No
contact lenses? Yes No

Check any of the following conditions that apply to your child:

Asthma Heart Diabetes Seizure Disorder

Describe: _____

Allergies: Bee Sting Peanut Food Medicine
 Animal/Insect Environmental Latex Other

Describe: _____

ADD/ADHD Migraine Orthopedic Stomach Urinary

Is your child presently under treatment / medical care? Yes No

Describe: _____

Doctor's name: _____ Phone number: _____

Does your child have any special needs or necessary precautions while in school? Yes No

Describe: _____

Is your child on any medication? (If 'yes' indicate here:) Home School

Name of the medication(s) _____

Reason for medication: _____

Dosage: _____ Time(s) of day: _____

HEALTH INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL

Parent/Guardian Signature Relationship Date