# Annual Health History  Year 20___ - 20___  School District 308

**TO BE COMPLETED BY PARENT/GUARDIAN**

| | | | | | |
|---|---|---|---|---|---|
| **Student's Name** Last First Middle | | | **Birth Date** Month Day Year | **Parent Name** | |
| | | | | **Parent Phone #** | |
| **Grade** | **Sex** M ☐ F ☐ | | **Physician** | **Phone** | |
| **School** | | **Comments** | **Hospital** (circle) Copley Mercy Edward | | **Comments** |
| Allergies? Specify. Allergies to Medication/ Environmental / Food / Stinging Insects **(circle)** | Yes ☐ No ☐ | Indicate severity & treatment: | Loss of Function of one of paired organs? Eye / Ear / Kidney / Testicle **(circle)** | Yes ☐ No ☐ | |
| Diagnosis of Asthma? Wakes during night coughing? | ☐ ☐ | Indicate severity: | Hospitalizations? When? What for? | ☐ ☐ | |
| Birth Defect? | ☐ ☐ | Type: | Serious injury/illness? When? What? | ☐ ☐ | |
| Blood Disorders? Hemophilia, Sickle Cell, Other? Explain | ☐ ☐ | | Surgery? (List all) When? What for? | ☐ ☐ | |
| Diabetes? Type I or Type II **(circle)** | ☐ ☐ | | Diagnosis of migraine headaches? Explain treatment used. | ☐ ☐ | |
| Head Injury/Concussion When? | ☐ ☐ | | Mental Health Concerns? Depression, Bipolar Disorder, other? Explain. | ☐ ☐ | |
| Diagnosis of seizure disorder? Type? How long do they last? Please describe. | ☐ ☐ | | Shunt? Right or Left **(circle)** What type? | ☐ ☐ | |
| Heart Problem / Current heart murmur? **(circle)** | ☐ ☐ | | Dental: Braces / Bridge / Plate **(circle)** | ☐ ☐ | Last dental exam? |
| High Blood Pressure? | ☐ ☐ | | **Pre K - K only** Developmental Delay? | ☐ ☐ | |
| Dizziness or chest pain with exercise? | ☐ ☐ | | Is your child potty trained (daytime)? | ☐ ☐ | |
| Bone/Joint Problems/Scoliosis? | ☐ ☐ | | If NO, are you interested in assistance with toilet training during the school day? | ☐ ☐ | |
| Ear/Hearing Problem/Frequent Ear Infections? Explain. | ☐ ☐ | | **Additional Comments?** | | |
| Medically-related dietary restrictions? Explain. | ☐ ☐ | | **Medications (List all prescribed or taken on a regular basis.)** | | |
| Eye/Vision Problems? Glasses/Contacts? (circle) | ☐ ☐ | Last eye exam? | | | |

**This information is shared with 911 providers in case of an emergency.**

**Parent/Guardian Signature** **Date**

Rev January 2014

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event reasonable attempts to contact me at the locations listed below are unsuccessful, I, as parent or legal guardian of **(name of student)** _____, so hereby authorize: (1) the treatment by a licensed medical physician of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence. (*please print)*

| | |
|---|---|
| **Guardian name:** | **Relation to student:** |
| **Address:** | **City:** |
| **Home phone:** | **Business phone:** |
| **Cell phone:** | **Other phone:** |

**This information is shared with 911 providers in case of emergency.**

_____ _____
Parent/Guardian Signature Date

## AUTHORIZATION TO RELEASE HEALTH RECORDS

I hereby authorize my child's health care provider and previous school to release my child's most recent physical, immunization, and other pertinent health information to CUSD 308 for completion of student health records. This authorization is valid while the student is enrolled in CUSD 308.

_____ _____
Parent/Guardian Signature Date

## PESTICIDE NOTIFICATION REQUEST

School District #308 practices Integrated Pest Management, a program that combines preventive techniques, non-chemical pest control methods, and the appropriate use of pesticides with a preference for products that are the least harmful to human health and the environment. The term "pesticide" includes insecticides, herbicides, rodenticides, and fungicides.

This school district is establishing a registry of people who wish to be notified prior to pesticide applications. To be included in this registry, please sign below.

If you have any questions or comments, please contact the, Director of Buildings and Grounds at 630-636-3171.

I would like to be notified two days before the use of pesticides at the school. I understand that if there is an immediate threat to health or property that requires treatment before notification can be sent out, I will receive notification as soon as possible.

_____ _____
Parent/Guardian Signature Date