STUDENT HEALTH SURVEY

_______________________ **M / F** ____________ ________ **☐ YES ☐ NO**

Student's Name **Gender** **Birthdate** **Grade** **New Student?**

* Check if student is **transferring** from: ☐ **Another IL School** ☐ **An Out-of-State School**

_______________________ / ____________ / ____________

Parent/Guardian Name (Please Print) **Phone Number** **Email Address**

PLEASE INDICATE IF YOUR CHILD HAS ANY CONDITIONS BELOW:

COMMENTS

YES **NO** Allergies **(Food, drugs, seasonal, pets)** ____________

* **Reaction** to above allergy **(What is child's response)** ____________

YES **NO** Asthma **(doctor confirmed/medication)** ____________

YES **NO** Diabetes **(doctor confirmed/medication)** ____________

YES **NO** MEDICATION(S) **(Specify Medication / Reason)** ____________

** Is medication taken at: ☐ **HOME** or ☐ **SCHOOL** ____________

(PLEASE NOTE: If medication is taken at school, a School Medication Authorization form for EACH medication will need to be completed and submitted to the school upon completion.)

PLEASE INDICATE IF YOUR CHILD HAS ANY CONDITIONS BELOW:

COMMENTS

YES **NO** Skin Condition **(Eczema, Rashes, Hives)** ____________

YES **NO** Orthotic Devices **(hand/knee braces/splints)** ____________

YES **NO** Muscular/Skeletal disease ____________
(Scoliosis, Muscular Dystrophy)

YES **NO** Seizure Disorder **(Type / Medications)** ____________

YES **NO** Neurological Disease / Disorder ____________
(Cerebral Palsy, Bell's Palsy, Brain Tumor, Multiple Sclerosis)

YES **NO** Birth Defects / Developmental Delay ____________

YES **NO** Head Injury **(History of Concussion)** ____________

YES **NO** Heart Problems or Conditions **(Murmur, High blood pressure)** ____________

YES **NO** Eye/Vision Problems or Conditions ____________
(Please be specific to what)
☐ Glasses / ☐ Contacts Prescribed Use: ☐ Near Vision ☐ Far Vision ☐ Reading

YES **NO** Ear/Hearing Problems or Conditions **(Please be specific to what)** ____________
☐ Ear Tubes ☐ Hearing Aid ☐ Other: ____________

Student's Name **Birthdate** **Grade**

PLEASE INDICATE IF YOUR CHILD HAS ANY CONDITIONS BELOW:

COMMENTS

YES **NO** Cancer **(Type, when diagnosed, treatment)** ____________________

YES **NO** Blood Disorders **(Sickle Cell, Hemophilia, Anemia, Leukemia)** ____________________

YES **NO** Metabolic disease **(Diabetes, Cystic Fibrosis)** ____________________

YES **NO** Gastrointestinal disorder **(Irritable Bowel Syndrome)** ____________________

YES **NO** Kidney or Bladder disorder **(Incontinence)** ____________________

YES **NO** Dietary Restrictions ____________________

YES **NO** Activity Restrictions ____________________

YES **NO** Serious Accidents / Injuries ____________________

YES **NO** Hospitalizations **(When? What for?)** ____________________

YES **NO** Surgery **(Type, When?)** ____________________

Additional Comments (Please list any other medical issues or concerns):

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CONSENT FOR EMERGENCY MEDICAL TREATMENT

I give consent/permission to Sandridge School District 172 in requesting the aid of the closest Rescue Unit in the event of a serious accident, injury or illness. ☐ **YES** ☐ **NO**

______________________________ ____________

PARENT/GUARDIAN SIGNATURE **DATE**