COUNTRY CLUB HILLS SCHOOL DISTRICT 160
Annual Student Health Information – 2009-2010

School:___ Grade:___ Student's Name:______________________________ Birthdate:________

Address:__________________________ Parent/Guardian Name:__________________________________

Home Phone:__________________ Work:______________________ Cell:____________________

Emergency Contact:____ Phone:______________________
(Available during school hours to pick up your child in case of an emergency.)

Doctor's Name:____ Phone:_______________________

Please update the following health information. If your child has a serious medical condition, please contact the Health Office at your child's school. If any information changes during the school year, please call the Health Office.

MEDICAL HISTORY: Check the following health concerns that apply and describe under the comment section.

__Allergies
__Arthritis
__Asthma
__ADD/ADHD
__Cerebral Palsy
__Diabetes(Type I/II)
__Emotional concerns
__Emotional concerns
__Epi-Pen
__Head Injury
__Headaches
__Hearing Loss
__Heart condition
__Kidney/urinary concerns
__Musculoskeletal disorder
__Neurological concern
__Seizures/Epilepsy
__Sickle Cell/Anemia
__Toileting concerns
__Vision concerns
__Weight concerns
__Other:____________________________ (explain)

Comments:____

____

ALLERGIES: List all allergies that your child has and the treatment.
Allergy:____
Food and Allergy:____

MEDICATION: List all prescription, over-the-counter, and herbal medication.

Name	Dosage Amount and Times, Used to Treat

List any operations, injuries, or hospitalizations. Give student's age and reason:____

____

Does your student wear glasses or contact lens? Yes__ No__ Hearing Aid Yes__ No__
If so, date of last eye exam:________________

I am in agreement that health information may be shared with appropriate personnel for health and educational purposes for my child.

____

Parent Name Parent Signature Date

RECORD OF STUDENT HEALTH OFFICE VISITS
(For Health Office Use Only)

Student Name:__________________________ **Signature** ______________________ **Initial** _____

Health Care Plan on File **Yes__ No__** ______________________ _____

______________________ _____

Allergy/Asthma Action Plan on File Yes__ No__
Authorization for Medication at School Yes__ No__
Inhaler________________________________ **Student carries inhaler Yes__ No__**

DATE	TIME	PROBLEM

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