COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Road * Arlington Heights, IL 60005
847-593-4300

ANNUAL STUDENT HEALTH AND MEDICAL EMERGENCY FORM

20 ___ - 20 ___ SCHOOL YEAR

Student: _____ Birth date _____
(last) (first)

Grade _____ Sex _____ School _____

Annual Health History Update

		YES	NO
1. Does this child have:	Allergies to food, medications or insect stings	_____	_____
	Asthma	_____	_____
	Any chronic illness	_____	_____
	A seizure disorder	_____	_____
	Any physical limitations	_____	_____
	Diabetes	_____	_____

Explain: _____
_____
_____

(If medications, inhaler or glucose monitoring, etc., needs to be done at school, please refer to the appropriate forms "Medication Guidelines" H-24; "School Medication Authorization" H-25; "Hold Harmless and Indemnification for the Self-Administration of Asthma Medication and/or Possession of an Epinephrine Auto-Injector (Epi-Pen®)" H-26. Complete proper form(s)and return it to the school nurse.)

		YES	NO
2. During the past 12 months has this child been:			
	Hospitalized (include surgeries)	_____	_____
	Seriously injured	_____	_____

Explain: _____
_____

	YES	NO
3. Does this child take medication on a regular basis?	_____	_____

Explain: _____
_____

(If medications, inhaler or glucose monitoring, etc., needs to be done at school, please complete the "School Medication Authorization" H-25 form and return it to the school nurse.)

	YES	NO
4. Are there any other health concerns that the nurse/teacher should be aware of?	_____	_____

Explain: _____
_____

Physician Contact Information

Physician Name: _____Phone:_____

Name of Practice: _____

Physician Address: _____

Emergency Medical Treatment Authorization

If the parent(s) or guardian(s) cannot be contacted in case of serious injury or illness, I authorize the school to take such emergency action as may be deemed necessary, to include the transportation of the student to a hospital or medical center. As a parent and/or guardian, I do herewith authorize treatment for this child by a qualified and licensed medical doctor in the event of a medical emergency, which in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Parent(Guardian) Name (please print):_____

Parent (Guardian) Signature_____Date_____

Return to your child's school health office.