MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT 201
YEARLY HEALTH INFORMATION

_____ SCHOOL YEAR GRADE: _____

Student Name: _____ Phone: _____ M / F Birthdate: _____

HOSPITAL PREFERENCE: Provena St. Joseph Medical Center _____ Morris Hospital _____

Doctor's Name: _____ Phone: _____ Last Exam: _____

Dentist's Name: _____ Phone: _____ Last Exam: _____

HEALTH HISTORY	YES	NO	COMMENTS (Be Specific)	HEALTH HISTORY	YES	NO	COMMENTS (Be specific)
Asthma? ***				Heart Problems?			
INHALER at school?				Eye/Vision Problems?			
ALLERGIES***: **FOOD**				Glasses/Contacts?			
SEASONAL				Concussion/Migraines			
OTHER				Seizures/Fainting			
EPI PEN at school? ***				Speech Problems?			
Birth Defects?				Stomach Problems?			
Developmental Disability?				Dietary Restrictions? ***			
Bone/Joint Problems?				Kidney/Urinary Problems?			
Dental Problem? Braces?				Hospitalizations/Surgery?			
Diabetes? ***				Skin condition?			
Hearing Problems?				Blood Disorders?			
Chronic Ear Infections?				Other Concerns?			

***Additional form required**

Please list all medications your child is taking at home or school:

MEDICATION	DOSE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: If your child will be taking medication at school, whether prescription or over-the-counter, **A PHYSICIAN MUST** complete the school **Medication Administration** form.

Does your child have any restrictions at school? **Yes** _____ **No** _____ If so a doctor's note is required.

(Circle one.)

Parent/Guardian Signature:_____ Date:_____