Adlai E. Stevenson High School
Health Emergency Form

Name of Student: _____ ID#: _____ DOB: _____ Grade: ____

HEALTH HISTORY

Allergies (Food, drug, insect, other):			**Medication (List all prescribed or taken on a regular basis):**		
Diagnosis of Asthma?	YES	NO	Loss of function of one of paired organs?	YES	NO
Child wakes during night from coughing?	YES	NO	Hospilizations? When? What for?	YES	NO
Birth defects?	YES	NO	Surgery? (List all) When? What For?	YES	NO
Developmental delays?	YES	NO	Serious injury or illness?	YES	NO
Blood disorders? Hemophilia, Sickle Cell, other? Explain	YES	NO	TB skin test positive (past/present)?	YES	NO
Diabetes?	YES	NO	TB disease? (past or present)?	YES	NO
Head injury/Concussion/Passed out?	YES	NO	Tobacco use (Type, frequency)?	YES	NO
Seizures? What are they like?	YES	NO	Alcohol/Drug use?	YES	NO
Heart problems/Shortness of breath?	YES	NO	Family history of sudden death before age 50? (Cause?)	YES	NO
Heart murmur/High blood pressure?	YES	NO	Dental: ____Braces ____ Bridge ____ Plate Other:		
Dizziness or chest pain with exercise?	YES	NO	Bone/Joint problem/injury/scoliosis?	YES	NO
Eye/Vision problems? Other eye concerns? Last seen by eye Dr. _____	YES	NO	Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problem?	YES	NO	Parent/Guardian Signature: Date:		

HOSPITAL/PHYSICAN CHOICE

Please check **one choice** for a **non-life threatening** emergency.
These are the only choices for our paramedics.

_____Condell Hospital _____Highland Park Hospital _____Lake Forest Hospital

Physician's Name: _____ Phone: _____

EMERGENCY CONTACT PROCEDURE

If a parent, legal guardian or the emergency contact person provided cannot be reached, a school official may assume the responsibility of arranging transportation for your child/ward to a medical facility. I give my permission for my child/ward to receive medical care deemed necessary by an attending physician.

I give my permission for the release of my child's/ward's medical records and/or information from our physician /health care provider to the Health Services office at Stevenson High School. This includes the Certificate of Child Health Examination, immunization record and health history.

I give my consent for Stevenson High School, and specifically SHS Nurses, to forward a copy of my child's appropriately verified immunization record and his/her physician's statement regarding these immunizations to Illinois Department of Public Health for review of compliance with Illinois State Immunization requirements by Jan Daniels or designee.

Parent/Guardian Signature: _____ Date: _____