THE WINNETKA PUBLIC SCHOOLS
DISTRICT 36

Dear Parents:

We ask that you complete and return this form when you come in and register your child for school. The following health information is desired so that we can better know your child and provide the best environment for his/her schooling.

Child's Name: _____ Birthdate: _____ Grade: _____

Parent or Guardian's Name: _____ School: _____

Child's Physician: _____ Date of Last Exam: _____

Physician's Address: _____ Telephone: _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING: (Please Check)

	Allergies, please list:
	Food Allergies, please list:
	Asthma/inhaler
	Diabetes
	Hearing Difficulties
	Eye problems
	Headaches
	Heart Disease
	Seizures
	Stomach Aches
	Other, please explain:

If your child is currently taking medication, please list below:

1. _____ 3. _____ 5. _____

2. _____ 4. _____ 6. _____

Are there any health concerns at this time that we should be aware of? (Please explain)

_____

_____

_____

_____ _____

Signature of Parent or Guardian Date

02/2013