District 115
YORKVILLE
Community Unit School District
Administrative Center · 800 Game Farm Road · Yorkville, Illinois 60560 · 630-553-4382 · y115.org

To help meet your child's health needs in school, we are asking that you complete this survey every year. Please contact the school nurse if you have any questions. Thank you.

Name_____ Male_____ Female_____ Date of birth_____

Attending school_____Grade_____

Please answer all the health/medical questions to the best of you r knowledge:

Does/should your child wear glasses? · YES · NO Have a history of hearing problem? · Yes · NO

Does your child wear contact lenses? · YES · NO Does your child wear hearing aids? · YES · NO

Has your child been diagnosed with any of the following conditions?

ADHD/ADD · YES · NO DIABETES · YES · NO

ASTHMA · YES · NO MIGRAINES · YES · NO

HEART PROBLEMS · YES · NO SEIZURE DISORDER · YES · NO

If yes to any of the above, please explain: _____
_____

Will your child take any medications during the school day while at school? · YES · NO **If YES, please list:

Medication_____ Dose_____ How often taken_____

Medication_____ Dose_____ How often taken_____

Medication_____ Dose_____ How often taken_____

*Medication forms are available online or through your child's school. Medication will n ot be given without a completed school medication form on file at your child's school.

Does your child have any of the following allergies? If YES, please check all items below that apply.

Bee/Insect stings? · YES · NO If YES, describe

Reactions:_____

Peanut/Nut? · YES · NO If YES, describe

Reactions:_____

Foods? · YES · NO If YES, describe

Reactions:_____

Please list any others:_____

How do you treat your child's allergy symptoms? · Epi Pen · Other_____