



Gavin School District 37

Health Information Form

STUDENT NAME:			GRADE:
DATE OF BIRTH:		SCHOOL YEAR:	
CONCERNS	YES	NO	EXPLANATION (if YES please explain)
Allergic to Bee Sting?			EpiPen? <input type="checkbox"/> YES <input type="checkbox"/> NO
Allergic to Medications?			List:
Allergic to Foods?			List
Seasonal Allergies?			Medications:
Asthmatic?			Medications:
Attention Deficit?			With Hyperactivity ? <input type="checkbox"/> YES <input type="checkbox"/> NO Medications:
Headaches/ Migraines?			Medications:
Visual Conditions?			Circle one: Contacts Glasses Both
Hearing Problems?			Hearing Aids: <input type="checkbox"/> YES <input type="checkbox"/> NO
Stomach Problems?			
Diabetic?			Pump: <input type="checkbox"/> YES <input type="checkbox"/> NO
Cardiac/ Heart Conditions?			
Convulsions/ Seizures/ Epileptic?			Medications:
Behavior/ Emotional Concerns?			
Other Medical Concerns?			

In the event of an emergency as a result of serious illness or injury, permission is hereby granted to transport my child to a medical facility and to provide necessary treatment. I understand that an attempt will be made by the school administration and/ or attending physician to contact me (or my spouse) in the most expeditious way possible. If said physician is not available to communicate with me (or my spouse) permission is hereby granted to the attending physician to proceed with necessary medical or surgical treatment and to admit him/ her to a medical facility if necessary.

Please note, documentation, for any medical condition, MUST be provided by a doctor.

Parent/GuardianSignature: _____

Date: _____

Phone Number: _____