Central Community Unit School District 301
Dr. Todd Stirn, Superintendent
Student Services Department, Health Services Division

New Student Health Questionnaire

Child's Name: ______________________________ Birth Date: ____________ Grade: ____________

An Individual Healthcare Plan (IHP) is necessary for students with asthma, diabetes, seizures, allergies, or other significant conditions. Forms are available on the district website or from the school health office.

1. Does your child have any **severe / life threatening allergies**? No Yes Explain: ____________________
   Specify treatment needed at school: ____________________
2. Does your child have any **mild / moderate allergies**? No Yes **Food**? ____________________
   Seasonal / environmental? ____________________
   Other? ____________________
   Specify treatment needed at school: ____________________
3. Does your child have **asthma**? No Yes How often? ____________ Triggers: ____________________
   Specify treatment needed at school: ____________________
4. Does your child have a history of **seizures**? No Yes What Type? ____________ How often? ____________
   Actions to be taken at school: ____________________
5. Does your child have any **cardiac / heart history**? No Yes Explain: ____________________
   Actions to be taken at school: ____________________
6. Does your child take any **medications** regularly? No Yes **Where?** at Home at School* Specify the medication, its purpose, dosage, frequency & other pertinent information: ____________________
   ____

   ***** *NOTE: Before any medications can be given at school, Med A or IHP forms must be completed by the parent/guardian and healthcare provider. See District website.*
7. Does your child have any **vision problems**? No Yes Glasses? No Yes Contacts? No Yes
   Specify problem(s) and treatment(s): ____________________
8. Does your child have any **hearing problems** or frequent ear infections? No Yes Which ear? Right Left Both
   Specify problem(s) and treatment(s): ____________________
9. Does your child have any **emotional / psychological** concerns? No Yes Drug use? No Yes Self-injury? No Yes
   Explain: ____________________
   List any medications/drugs: ____________________
   Actions to be taken at school: ____________________
10. Is there **anything else** about your child's medical, physical, or emotional health that you would like staff to know? ____________
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Authorization: I hereby authorize CCUSD 301 staff to release my child's health information / records to teachers, administration, transportation, sports coaches, and food service personnel for the purpose of treating or preparing for a medical situation for my child. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I prefer not to sign below, it will not interfere with my child's ability to obtain health care.

Name & Signature of Parent/Guardian:______________________________ Date: ____________