CENTRAL
UNIT SCHOOL DISTRICT 301

New Student Health Questionnaire

Child's Name: _____ Birth Date: _____ Grade: _____

An Individual Healthcare Plan (IHP) is necessary for students with asthma, diabetes, seizures, severe allergies, or other significant conditions. Forms are available on the district website (www.central301.net) 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? _____

    _____

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: _____