Student Medical Information

School District 154
Thornton, Illinois

Date: _____

Student Name: _____
First Middle Last

Date of Birth:_____ **Grade Level:**_____**Phone:**_____

Address:_____ **City:**_____

Mother's Name:_____ **Natural**_____ **Step**_____ **Adopted**_____ **Foster**_____

Father's Name:_____ **Natural**_____ **Step**_____ **Adopted**_____ **Foster**_____

Guardian's Name:_____

Child Live with: Father_____ **Mother**_____ **Stepfather**_____ **Stepmother**_____ **Other**_____

Name of Family Physician:_____**Phone:**_____

Name of Family Dentist:_____ **Phone:**_____

MEDICAL HISTORY

Has your child ever had or been treated for any of the following? (Check all that apply)

Chicken Pox_____ **Date:**_____ **Epilepsy**_____ **Date:**_____ **Ear Infections**_____ **Date:**_____

Diabetes_____ **Date:**_____ **Heart Disease:**_____ **Date:**_____ **Asthma**_____ **Date:**_____

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

_____

Surgery (Type):_____ **Date:**_____

Result:_____

Serious Injuries / Accidents:_____ **Date:**_____

Explain:_____

Permanent Disabilities:_____ **Date:**_____

Explain:_____

Allergies:_____ **Type(s) of Allergy:**_____

Medication for Allergy:_____

Other (Please Specify):_____

Is your child presently being treated for a health problem?_____ **Please explain:**_____

Does your child wear glasses?_____ **Contacts?**_____ **Comments:**_____

Does your child have known hearing loss?_____ **Comments:**_____

If unable to reach you, who should we call in case of an accident or illness?

Name:_____

Phone:_____