

Cook County

**COMMUNITY CONSOLIDATED SCHOOL DISTRICT NO. 21**

999 West Dundee Road

Wheeling, Illinois 60090-3997

**HEALTH INFORMATION**

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

Please fill in below that which applies:

1. Does your child wear glasses?  Yes  No Contacts?  Yes  No

2. Does your child have a history of hearing problems? Explain: \_\_\_\_\_

3. Check any of the following conditions that apply to your child: \_\_\_\_\_

Asthma  Diabetes  Migraines  Insect Stings  Heart  Seizure Disorder

Stomach  Urinary  A.D.D.  List Allergies \_\_\_\_\_

Other, please describe. \_\_\_\_\_

4. Will your child need medication during school hours? Explain: \_\_\_\_\_

5. Is your child currently taking medication at home? Explain: \_\_\_\_\_

6. Are there restrictions to regular P.E.? (Beyond 5 days must be verified by doctor.)

**EMERGENCY AUTHORIZATION & INFORMATION (CUSTODY)**

Legal custody restricted to:

Both Parents  Mother  Father  Other

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Number order of contact (1-5)

Home Telephone: ( ) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Work Telephone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. In the event of any emergency arising out of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. **In case of emergency, attempt to contact a parent at home or at work. If we cannot be reached, attempt to contact the alternate listed.**

\_\_\_\_\_  
*Parent/Guardian's Signature*

\_\_\_\_\_  
*Date*

Health Services  
/pt