Plainfield Community Consolidated School District 202

We prepare learners for the future.

Administration Center
15732 Howard Street
Plainfield, IL 60544

(815) 577-4000 – telephone
(815) 436-7824 – main fax
Web: www.psd202.org

Student Health History

Student Name: _____ Grade: _____ School: _____

Sex: ☐ Male ☐ Female Birth Date: _____ Phone Number: _____

Doctor's Name: _____

(if you indicate YES for any category, please explain)

#	Concern	Yes or No	Explanation & Comments
1	Allergies	☐ Yes ☐ No	
	*Uses EpiPen	☐ Yes ☐ No	
2	Asthma	☐ Yes ☐ No	
	*Uses Inhaler	☐ Yes ☐ No	☐ Rarely ☐ Once daily ☐ More than once daily ☐ For Sports
	*Uses Inhaler at School	☐ Yes ☐ No	
3	Blood Disorders	☐ Yes ☐ No	
4	Daily Medications	☐ Yes ☐ No	
	*Names of Medication(s)	At home	
	School Medications REQUIRE Medical Authorization Form	At school	
5	Diabetes	☐ Yes ☐ No	
6	Ear / Hearing Problems	☐ Yes ☐ No	
7	Glasses / Contacts	☐ Yes ☐ No	Last eye exam:
8	Eye / Vision Problems	☐ Yes ☐ No	
9	Heart Problems	☐ Yes ☐ No	
10	Hospitalizations	☐ Yes ☐ No	Age:
11	Mental Health Concerns	☐ Yes ☐ No	
12	Neurological Problems	☐ Yes ☐ No	
13	Physical Restrictions	☐ Yes ☐ No	
14	Seizures	☐ Yes ☐ No	
15	Serious Injuries	☐ Yes ☐ No	Age:
16	Surgery	☐ Yes ☐ No	Age:
17	Other	☐ Yes ☐ No	

I release this information to be shared with appropriate school and emergency personnel for health and educational purposes.

_____ _____
Parent / Guardian Signature Date