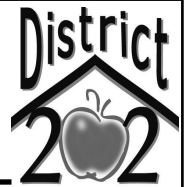


# Plainfield Community Consolidated School District 202

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

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

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date