Intermediate School District 917
Annual Health Information

Student _____ **Birth Date** _____
Diagnosis, if any _____ **School Year** _____

Parent/Guardian: Please complete the following questions concerning your child's health information.

Current Medications (All) **Name** **Dose** **Times** **Reason**

_____
_____
_____
_____
_____
_____
_____

Specialized Healthcare Procedures _____
_____

Allergies to Medication YES ☐ NO ☐ If yes, please list _____
Type of Reaction _____

SEVERE Allergies (example: food, pollen, insects, etc.) YES ☐ NO ☐ If yes, please list _____
Type of Reaction _____

Food Sensitivity (Intolerances) or other (i.e. seasonal allergy): Yes ☐ No ☐ If Yes, Please list below:
_____

Pregnancy and Birth Briefly describe any health problems experienced by mother during this pregnancy/birth problems/ concerns _____

Did any of the following occur during the birth process?
☐ Premature ☐ Caesarean section ☐ Breech birth ☐ Fetal distress ☐ Prolonged labor ☐ Transfusion

Hearing Loss YES ☐ NO ☐
☐ Right ☐ Left ☐ Both
Hearing Aids YES ☐ NO ☐
Last Hearing Test _____
Comments _____

Vision Loss YES ☐ NO ☐
☐ Right ☐ Left ☐ Both
Glasses YES ☐ NO ☐ Contacts YES ☐ NO ☐
Last Eye Exam _____
Comments _____

Last Physical Exam _____ **Clinic** _____

Last Dental Exam _____ **Clinic** _____

Immunizations
Is your child exempt from any of the childhood immunizations? YES ☐ NO ☐ If yes, what are they?

Is your child's immunization record up to date? YES ☐ NO ☐ **Provide a copy of up to date immunizations record from your provider.**

COMPLETE PAGE TWO

Please check the following that apply to your child and explain any past/current problems below:

	PAST	NOW		PAST	NOW
Accidents (serious)	☐	☐	Illness (serious)	☐	☐
ADD/ADHD	☐	☐	Joint & Bone Problems	☐	☐
Asthma	☐	☐	Lead Exposure	☐	☐
Autism	☐	☐	Menstrual Problems	☐	☐
Blood Disorder	☐	☐	Muscle Problems	☐	☐
Constipation	☐	☐	Seizure Disorder	☐	☐
Developmental Delay	☐	☐	Skin Problems	☐	☐
Diabetes	☐	☐	Sleep Disturbances	☐	☐
Ear Conditions/Infections	☐	☐	Speech Problems	☐	☐
Eye Conditions	☐	☐	Stomach Problems	☐	☐
Frequent Colds/Sore Throat	☐	☐	Surgeries	☐	☐
Headaches	☐	☐	Urinary Problems	☐	☐
Heart Problems	☐	☐	Other _____	☐	☐
High Blood Pressure	☐	☐	_____	☐	☐

PLEASE EXPLAIN ANY PAST/CURRENT PROBLEMS _____

_____

Describe normal sleep pattern _____

Behavioral/Emotional Problems (*Please **check** any problems your child exhibits and **explain** as needed.*)

☐ Aggression	☐ Hyperactivity	☐ Injurious Behaviors (Self/Property/Others)
☐ Anxiety	☐ Impulsiveness	☐ Repetitive Behaviors
☐ Depression	☐ Inattention	☐ School Avoidance
☐ Distractibility	☐ Increased Physical Complaints	☐ Withdrawn Behavior
☐ High Risk Behaviors (Chemical Use/Smoking/Other)		

Other _____

Comments _____

Other Evaluations (*Please **check** any evaluations your child may have had and **explain**.)*

Audiology ☐ Medical ☐ Physical Therapy ☐ Psychological ☐ Occupational Therapy ☐ Speech/Language ☐

Date of Evaluation Physician/Clinic Reason for Evaluation

_____

_____

_____

_____

Specialist Names, if applicable *Medical Specialty* *Phone/Fax Number*

(Family physician's contact information already indicated on Student Emergency Contact Form)

1. _____ **Phone** (___) _____
   Clinic Name / Address _____ **Fax** (___) _____
2. _____ **Phone** (___) _____
   Clinic Name / Address _____ **Fax** (___) _____
3. _____ **Phone** (___) _____
   Clinic Name / Address _____ **Fax** (___) _____

_____ _____

Parent/Guardian Signature *(If completed by another adult, indicate relationship)* **Date**

For office use only:

LSN Signature _____ Date _____

Name of Staff Routing _____ Date _____

Please check off who was routed this form ___Student File __ IEP Manager ___ 917 LSN ___Building Nurse