FOX RIVER GROVE SCHOOL DISTRICT 3

Annual Health Services Survey

Student Name: ____ **Grade:** _________

As you know, good health is vital for an optimal learning experience. To provide the best care possible during school hours the district asks that you please complete the following form to help us meet your child's health related needs. Please call the district nurse at (847) 462-2418 if you have any concerns or issues regarding your child's health. Thank you.

ALLERGIES
What is your child allergic to? (Please include medication, environmental, food, seasonal allergies, etc.)
____
What is your child's usual or past reaction? ____swelling ____hives ____rash ____difficulty breathing/swallowing/talking _____other-, explain: _________________________________
What is the action to be taken in case of a reaction at school?
___Medication (list) ___________________ *Please note-permission forms (found on our website or at the front office) for medication administration are required.
___Call Parent only
___Call EMS and parent immediately (applies for all Epi-Pen use) Does your child carry an Epi-Pen? ___ * Epi-pens also need medication permission forms as well.

ASTHMA
During the school year, how often does your child have attacks? _______________________
Causes of asthma attacks: ____allergies ____infections ____weather ____exercise ___ other-, explain:
____
Usual symptoms: ____wheezing ____coughing ____difficulty breathing ____feeling of tightness in chest
____other-, explain: ____
Treatment for attacks-, ____rest ____liquids ____medications (list) ______________________

SEIZURE DISORDER
Type of seizure ________________________________ Approximate date of last seizure or age at time of last seizure ___________________ Average duration of seizures ____________
Does your child take anti-seizure medication? _____ Name of medication(s) _______________
List any special instructions for care during/after a seizure ____________________________

DIABETES
Age of diagnosis __________ Diet restrictions at school _____________________________
Action to be taken for hypoglycemic reaction _____________________________________
Date of last serious reaction ____________ Type of insulin used _____________________
Will student be performing blood sugar monitoring at school? _______________________
What are acceptable blood sugar parameters for your child? ___________________________

HEART CONDITIONS
Describe any heart problem ____
Describe any activity restrictions/medications _____________________________________

OTHER HEALTH CONCERNS / OTHER MEDICATIONS NOT PREVIOUSLY LISTED
(Please include ADHD, any dental problems, orthopedic conditions, hearing aids, etc.)
____

Authorization: I hereby authorize Fox River Grove District health personnel to release my child's health information/records to teachers, administration, transportation and food services personnel for the purpose of treating, or preparing for, a medical situation for my child. This authorization is valid for one calendar year. It will expire on _________ I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent.

____
Parent Signature Date