Sandoval Community Unit School District #501
School Health History

Student's Name: _____ Grade: _____

Please answer the following yes/no questions. If you answer yes, please explain in area provided.

ALLERGIES Food Drug Insect other	Yes No	Comments:	Blood Disorder? Hemophilia Sickle Cell Other	Yes No	Comments:
Asthma?	Yes No		Seizures?	Yes No	
Dizziness/chest pain with exercise?	Yes No		Female/Reproductive problems?	Yes No	
Developmental Delay	Yes No		Dietary Needs, Restrictions Allergies?	Yes No	
Serious injury or illness?	Yes No		Mental Health Concerns?	Yes No	
Diabetes? Insulin?	Yes No		Bone/Joint problems?	Yes No	
Heart Problems? Shortness of breath Heart murmur High Blood Pressure	Yes No		Ear/Hearing problems? Tubes Hearing Aides	Yes No	
Headaches/Migraines?	Yes No		Birth Defects?	Yes No	
Eye/Vision problems? Glasses Contacts	Yes No		Head Injury? Concussion Loss of consciousness	Yes No	
List ALL medications:					
Hospitalizations or Surgeries:					

Student's Doctor/City: _____ **Phone:** _____

Consent for Emergency Care & Treatment AND Release of Medical/Dental Information

I, parent/guardian of _____ (child's name) give consent to release medical/dental information to Sandoval School District for the sole purpose of meeting required State of Illinois guidelines for my child to attend school.

In the event of an emergency involving my child, I grant permission for school authorities to seek medical care. In addition, I understand appropriate medical care may include emergency assistance and/or hospitalization. I authorize the attending physician to render medical and emergency care to my child as necessary. I agree to assume all responsibility and expense, including transportation costs, incurred for providing medical care.

Parent/Guardian Signature _____ Date _____