COMMUNITY UNIT SCHOOL DISTRICT 95
Health Office Emergency Information

Student Name_____**Home Phone**_____

Student Address_____IL_____
Street City State Zip

Date of Birth_____Gender____ Registering for Grade:_____ **Student Lives With**: Mom_____ Dad_____Both_____Guardian_____
Month Day Year

Mother/
Guardian Name_____Business Phone_____Cell Phone_____
Father/
Guardian Name_____Business Phone_____Cell Phone_____

In case of emergency, who should be called if parents cannot be contacted? Please give daytime phone numbers.

Name_____Phone_____

Name_____Phone_____

Doctor _____Phone_____

Social Security # _____ Medicaid #_____

In the event of an emergency and medical attention is necessary in the judgment of school authorities, do you authorize them to seek emergency medical services and transportation for your child? Yes____ No____
Reasonable effort will be made to notify you or your emergency contacts after services have been initiated.

Parent/Guardian Signature_____**Date**_____

CONFIDENTIAL HEALTH INFORMATION	**Check all that apply.**	**Please explain any yes answers.**
Food Allergy	No____Yes____	_____
Bee Sting Allergy	No____Yes____	_____
Other Allergies (Specify)	No____Yes____	_____
Asthma	No____Yes____	_____
Bowel/Bladder Concerns	No____Yes____	_____
Diabetes	No____Yes____	_____
Heart Condition	No____Yes____	_____
Seizures	No____Yes____	_____
Skin Condition	No____Yes____	_____
ADHD	No____Yes____	_____
Emotional Health Concerns	No____Yes____	_____
Hearing Concerns	No____Yes____	_____
Vision Concerns	No____Yes____	_____
Other (Specify)	No____Yes____	_____

MEDICATION

Medication taken at home No____Yes____ List_____

Medication needed at school No____Yes____ List_____

School Medication Authorization form must be on file in Health Office for medicine to be administered by health office personnel.

Medical information on this card and in your child's health record may be shared with the educational staff to maintain your child's health and safety in the school setting. The school district is not responsible for any health concerns that are not addressed on this form.