RIVER FOREST COMMUNITY SCHOOL CORPORATION
School Health Services

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NEW/RE-ENROLLED STUDENT HEALTH INFORMATION

Date: _____

Student's Full Name _____ Birthdate _____ Grade _____
(last) (first) (middle)

Previous School _____

Previous School's Phone Number _____
Has this student ever attended any River Forest School prior? Yes or No.
If yes which school: EVANS MEISTER RFE RFHS RFJH

Does the student have any of the following health conditions? ( ) No ( ) Yes (if "Yes" please check below)

( ) Asthma-is an inhaler needed ( ) No ( ) Yes
Type of inhaler_____
( ) Frequent colds
( ) Frequent sore throats
( ) Frequent ear infections
( ) Eczema or frequent skin rashes
( ) Allergies (check all that apply)
( ) Bee stings-type of reaction _____
( ) Foods-types_____
( ) Other-please list_____
If a reaction should occur, what should be done?_____
_____
_____

( ) Diabetes-type_____
( ) Seizure disorder-type _____
( ) Heart problems/irregularities_____
( ) Kidney/bladder problems _____
( ) Sight impairment
( ) Glasses
( ) Contacts
( ) Other (please list) _____
( ) Hearing impairment
( ) Hearing aid(s)
( ) Other_____
( ) Other _____

( ) Physical handicap (describe)_____

_____

Please list any physical restrictions the student has: _____

_____

_____

( ) Other problems or conditions that may impact on the school day (i.e. Anxiety, ADHD, Depression) _____

_____

Give **DETAILED** information on all items checked above and explain how the student may be affected (Example: Bee sting allergy-causes swelling at sight). _____

_____

(Over)

Disease History (Please give dates)

Chicken Pox _____ Measles _____ Rubella _____
Scarlet Fever _____ Pneumonia _____ Other _____

Past Medical History (information and dates)

Significant past illness _____

Serious injury or accident _____

Operations _____

Does the student take any medication regularly? ( ) No ( ) Yes (list medication(s), dosage(s), frequency, and reason): _____

_____

Medication required during school hours: (1) _____ (reason) _____ Time: _____
(2) _____ (reason) _____ Time: _____

IF A DOCTOR /DENTIST CARE SEEMS NECESSARY, CAN WE CALL YOUR DOCTOR/DENTIST? ( ) YES ( ) NO (If you do not have a doctor/dentist at this time, please supply us with this information at another time.)

_____ _____
NAME OF FAMILY DOCTOR PHONE

_____ _____
NAME OF FAMILY DENTIST PHONE

I understand that I may be required to furnish a doctor's statement verifying the above information. I, also understand that this information is CONFIDENTIAL; is being furnished for the exclusive use of the River Forest Community School Health Services Department, and any other necessary school personnel.

I give permission for this medical information to be shared with appropriate school staff to ensure my child's safety and to best meet his/her educational needs. This information may be furnished in the form of a confidential medical list or through computer. If you do not want your child to be part of this list, please provide a written refusal statement to the school nurse/nurse assistant.

Parent/Guardian Signature: _____ Date: _____

PLEASE SEND ANY UPDATED IMMUNIZATION RECORDS YOU HAVE RECEIVED.

IF YOUR CHILD IS GOING TO BE TAKING PRESCRIPTIVE OR NON-PRESCRIPTIVE MEDICATION AN AUTHORIZATION FORM NEEDS TO BE COMPLETED. THE AUTHORIZATION FOR MEDICATION FORMS IS LOCATED IN THE NURSE'S OFFICE AND IN THE MAIN OFFICE.