# Tonica Community Consolidated School District #79

Student Health History
2022-2023
*Medical Provider diagnosis required for any item listed and medical plans*

This form will be sent with other medical information if a student is transported for an emergency situation.

Student Name:_____ Birth Date:_____ Grade:_____

Address:_____

Parent(s)/Guardian Name(s):_____

Father - Phone 1:_____ Phone 2:_____

Mother - Phone 3:_____ Phone 2:_____

Physician:_____ Phone:_____

Medical Plan In Place: Yes_____ Type: Diabetic Seizure Allergy Other:_____ No_____

Medication Form on File: Yes_____ Expiration date:_____ No_____

List Medications that will be at school or with child and for what use:_____

_____

_____

**Asthma:** Diagnosis: Yes_____ No_____ Specialist_____

- Frequency of asthma attack?_____ Date of last attack requiring ER/Urgent Care_____
- What causes an attack? Allergies_____Infections_____Weather_____Exercise_____
    - Anything not listed:_____
- Usual Symptoms:_____
- Method of treatment:_____
- Best Peak Flow (if known):_____

**Allergies:** Diagnosis: Yes_____ No_____ Specialist_____

- What causes an allergic reaction?_____
- Usual or past reactions? Redness_____Swelling_____Itching_____Hives_____Rash_____
    - Anything not listed:_____
- Action to be taken in case of reaction during school:
    - Medications(s) that parents must supply:_____
        - Medication Form required from physician including for OTC medications
    - Contact parent_____Call 911 (applies to all epi-pen use):_____

**Seizure Disorder:** Diagnosis: Yes_____ No_____ Specialist_____

- Type of seizures:_____
- Age of diagnosis:_____Average length of seizure:_____
- Date of last seizure:_____Medication: Yes_____No_____
- Name of Medication(s) parents must supply:_____
- Date medication last used:_____Will Medications be needed at school:_____

**Diabetes:** Diagnosis: Yes_____ No_____ Specialist_____

- Type 1_____ Type 2_____ Age of Diagnosis:_____
- Does your child have an insulin therapy pump: Yes_____ No_____
    - What is the name of the brand:_____
- Does your child use injections: Yes_____ No_____
    - Is your child self-sufficient with their diabetes care: Yes_____ No_____

Other health needs or concerns (included ADHD, mental health, dental issues, orthopedic conditions, genetic disorders, etc.):_____

_____

Any medications taken that you have not already listed:_____

_____

All medications that will be taken during school hours must be accompanied by the Medication Authorization Form including OTC medications. A parent may come to the school with a medication and administer to a student if a form is not on file. Medications at school are for long term, required to attend/function at school and not for short-term medical conditions.

Does your child wear glasses? Yes_____No_____ Does your child wear contacts? Yes____No_____

Does your child have a hearing impairment? Yes_____No_____

Does your child utilize a prescribed hearing assistive device? Yes_____No_____

<u>Emergency Information: All students must have 2 emergency contacts that are within 30 minutes of Tonica other than the parents.</u>

<u>Emergency Contact 1</u>

Name:_____Phone_____Relation_____

<u>Emergency Contact 2</u>

Name:_____Phone_____Relation_____