Tonica Community Consolidated School District #79

Student Health History
2024-2025
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:________________________________

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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:____________________________________

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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____

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

Emergency Contact 1

Name:__________________________________Phone_____________________Relation___________________

Emergency Contact 2

Name:__________________________________Phone_____________________Relation___________________