

STUDENT HEALTH AND EMERGENCY INFORMATION- One per student

Patient Information				
Student LAST Name:		Student FIRST Name:		Date of Birth:
Grade in the fall: <input type="checkbox"/> Senior <input type="checkbox"/> Junior <input type="checkbox"/> Sophomore <input type="checkbox"/> Freshman		Home #: ()		Cell#: ()
Home Address:		City:		Zip:
Mother's full name:		Mom's email:	Mom's cell #:	Mom's work#:
Father's full name:		Dad's email:	Dad's cell#:	Dad's work#:
<u>Primary Physician:</u>			<u>Physician's Phone Number:</u>	
EMERGENCY CONTACTS- If parent is not available. Must be in Illinois				
Name:	Relationship	Home Phone	Cell Phone	Work Phone:
MEDICAL CONDITIONS: Check all that apply				
<input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Asthma <input type="checkbox"/> Asthma Exercise Induced <input type="checkbox"/> Cardiac Condition <input type="checkbox"/> Concussion: list date/s below <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Diabetes- Insulin Injection <input type="checkbox"/> Diabetes- Insulin Pump <input type="checkbox"/> Diabetes- Oral Medication <input type="checkbox"/> Depression	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hyper/Hypo thyroid <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Migraine <input type="checkbox"/> Mobility Impairment <input type="checkbox"/> Fainting <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Seizures	ALLERIGIES: <input type="checkbox"/> Bee/Wasp sting <input type="checkbox"/> Eggs <input type="checkbox"/> Fruit <input type="checkbox"/> Latex <input type="checkbox"/> Milk <input type="checkbox"/> Peanut <input type="checkbox"/> Shellfish <input type="checkbox"/> Soy <input type="checkbox"/> Tree Nut <input type="checkbox"/> Other- specify below. Include medications/ Allergies	MEDICATIONS: <input type="checkbox"/> Epipen <input type="checkbox"/> Benadryl <input type="checkbox"/> Rescue Inhaler <input type="checkbox"/> Other-please list below	May Acetaminophen be given to this student by the nurse? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last Tetanus Vaccine: Mo:___ Yr: ___
Other:				