Community Unit School District 303
Health Services Survey

In an effort to best serve our students, we request that you provide current health information.

1. Has your child had a serious illness, injury or surgical procedure within the past year? Yes ☐ No ☐
If yes, please explain: _____

_____

Will your child require medication, restrictions, or accommodations at school? Yes ☐ No ☐

2. Does your child have a known allergy/sensitivity that may impact him or her at school? Yes ☐ No ☐
If yes, please explain: _____

_____

Is your child's allergy considered life-threatening? Yes ☐ No ☐
Please list all allergy medications your child has been prescribed:

_____

Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

3. Does your child have asthma? Yes ☐ No ☐
Is your child's asthma: ☐mild ☐moderate ☐severe?
Is your child's asthma: ☐seasonal ☐exercise ☐illness ☐allergy induced?
Please list all medications your child takes for asthma:

_____

Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

4. Does your child have a history of seizures? Yes ☐ No ☐
If yes, please explain the nature of your child's seizure history: _____

_____

When did the last seizure occur? _____
Please list any seizure medications your child currently takes:

_____

Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

5. Does your child have a history of cardiac concerns? Yes ☐ No ☐
If yes, please explain the nature of your child's cardiac history: _____

_____

Is your child currently under the care of a cardiologist? Yes ☐ No ☐
Please list all cardiac medications your child takes:

_____

Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

6. Does your child have any other health concerns; physical, emotional or attention related, that could impact him or her while at school? Yes ☐ No ☐
If yes, please explain: _____

_____

Does your child take medication at home? Yes ☐ No ☐
If yes, please indicate: _____
Does your child require medication, restrictions or accommodations at school? Yes ☐ No ☐
Please indicate: _____

7. Does your child wear glasses/contacts and/or have a visual impairment? Yes ☐ No ☐
If yes, please explain the nature of the visual impairment:

8. Does your child have a known hearing loss, ear tubes or frequent ear infections? Yes ☐ No ☐
If yes, please explain the nature and frequency of your child's hearing difficulty:

This information will be kept confidential and shared only with educational personnel on a need to know basis.
Please contact your school nurse if this information is not to be shared.
Health information and health forms are available under Parents/Forms/Health Forms at www.d303.org

Child's Name: _____ Grade: _____ School Year: _____