Community Unit School District 303
Health Services Survey

In 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 or severe? ***Please circle one***
   Is your child's asthma seasonal, exercise, illness, or allergy induced? ***Circle all that apply***
   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? If yes, please indicate: Yes ☐ No ☐

   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:_____

Parent/Guardian Signature:_____ School Year: _____