HEALTH HISTORY
BUSHNELL-PRAIRIE CITY SCHOOLS

Student Name:_____ Birth Date:_____

Dear Parent,

The information that you provide about your child's health conditions may be disclosed to your child's teacher(s) as well as other school staff as needed to protect your child's health and safety at school. Please check any conditions that apply and give additional information as indicated.

__Allergies: To what?_____
Symptoms your child has:_____
Are medications used to treat symptoms:_____
Has your child ever been given a written prescription for epinephrine? Yes no

__Asthma : What triggers or causes asthma symptoms in your child?_____
__Exercise __Respiratory infection __Change in temperature __Animals
__Food __Strong odors or fumes __Dust __Pollens __Molds
__Carpets in rooms __Others:_____
Medications used to treat symptoms: _____

___Diabetes: Type_____ Medications: _____

___Seizures: Type_____ Date of Last Seizure: _____
Current anti seizure medication: _____

___Hearing loss or impairment: ____wears hearing aid ____other
___Recurrent ear infection: yes no Tube Placement: yes no

___Vision impairment: yes no Describe:_____
wears glasses or contacts? Yes no

___Other conditions which may affect your child's abilities in the classroom and that you want the teacher to be aware of such as ADHD, ADD, Bipolar, autism, depression, schizophrenia, anxiety disorders? If so, what medications does your child take for these?
_____

_____

___Other health conditions such as anemia, birth defects, bone, joint or muscle problems, hemophilia, heart problems, ulcers, colitis, cystic fibrosis, cancers, hydrocephalus, cerebral palsy, arthritis, kidney, bladder or bowel problems (including urine or stool accidents during the day or night) skin conditions, eczema, etc. Please describe, list any medications used for the condition, and accommodations needed such as special seating, bathroom privileges, etc...
_____

_____

_____

___Surgeries: type and date: _____
___Hospitalizations: date and cause_____
___Activity limitations: _____

___Special diet or food restrictions: _____
PLEASE HAVE YOUR HEALTH CARE PROVIDER COMPLETE THE FOOD ALLERGY FORM (These need to be updated at the beginning of each school year).

When was the last time your child was seen by the dentist? _____
By a doctor? _____

All medications taken at school require yearly written physician and parent permission. Life saving medications may be carried by the student when appropriate. Other medication must be kept in the school office, be in a pharmacy or manufacturer labeled container, and delivered to the school by the parent. Please ask for correct forms.

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school the call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make necessary arrangements.

In case of emergency: Doctor: _____ Phone: _____

_____ _____
Parent Signature Date

I have reviewed and updated my child's Health History form

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

HEALTH HISTORY
BUSHNELL-PRAIRIE CITY SCHOOLS

PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

Dear Parent/Guardian:

This school participates in a federally-funded School-Based Child Nutrition Program and must serve meals and/or milk meeting program requirements. Reasonable food accommodations must be made when the accommodation being requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact me at 309-772-9464.

Sincerely,
Kristi White

DATE: _____
CHILD'S NAME: _____ GRADE:_____

I certify the above named child has food allergies/intolerances to the following food(s):

_____PEANUT

_____OTHER NUTS: Please list_____

_____MILK/DAIRY

_____Lactose Intolerance (does not drink milk, but may have it in food products)
_____Needs to avoid all milk products
_____Cheese
**To meet the Nutrition Program requirements, we are required to provide milk with a school lunch, we will no longer offer juice as a milk substitute, we will be offering a lactose free milk product.
For students who don't like milk: they will be given milk on their tray, but may purchase a water bottle to drink at lunch.

_____Other food allergies (Please list):_____

List foods that may be substituted:_____.

_____ _____ _____
(DATE) (Physician Signature) (Telephone #)