

DEERFIELD COMMUNITY SCHOOL DISTRICT – HEALTH AND CUSTODY INFORMATION
Annual update by parents/guardians required.

HEALTH SURVEY/INFORMATION: This information must be updated annually to ensure our records are current.

Student Name:		DOB:	Grade:
YES (✓)	NO (✓)		
		Severe reaction to insect stings. Cause/Reaction:	
		Food allergies. Cause/Reaction:	
		Other allergies. Cause/Reaction:	
		* Epi-pen at school:	<input type="checkbox"/> In School Health Office <input type="checkbox"/> With Student
		Asthma (check one):	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
		Cause/Reaction:	
		* Inhaler at school:	<input type="checkbox"/> In School Health Office <input type="checkbox"/> With Student
		Heart condition (describe):	
		Vision loss (not corrected by glasses):	
		Hearing loss (describe):	
		Emotional problems (describe):	
		Diabetes (describe):	
		Seizures (describe):	
		Migraines/Headaches (describe):	
		Physical limitations (please list):	
		Student is taking medication at home that the school needs to be aware of: List Medication:	
*Please list any medications the student will be taking at school: (NOTE: Students in grades 4K-12 may not self-administer any medication which is a controlled substance (i.e., ADHD medications such as Ritalin, Pain medications, etc.)			
Location of medication:		<input type="checkbox"/> In School Health Office	<input type="checkbox"/> With Student
Please complete with date any new immunization boosters the student has received:			
Varicella (chicken pox)_____ Tdap_____ Td_____ Other _____			

***Students who require prescription or over the counter medication during school hours must have a current medication consent form completed and signed by their parent/guardian and/or medical practitioner.** This form must be submitted to the office **prior to** medication being administered or taken at school. Medication must come in the original container and be appropriately labeled. **Forms can be found in the student handbook, on the district website, or in the school office.**

Additional Pertinent Medical Information:	
The parent/guardian signature below:	
<ul style="list-style-type: none"> • allows the school to share health concern information with school staff, bus drivers & coaches/advisors that may come in contact with the student. • authorizes treatment by an EMT or licensed trainer for my child in the case of an injury or medical emergency. • authorizes that information regarding treatment or injury may be shared between EMT or licensed trainer and the appropriate school district staff. • authorizes that the name & location of the facility treating my child be released to the school district if such need occurs under district supervision. 	
Signature:	Date: