E.H. Mellon Administrative Center

703 S. New Street
Champaign, Illinois 61820-5818

Telephone: (217) 351-3800
FAX: (217) 351-3871

Student Name: _____ School: _____ Entering Grade:_____

Name/Relationship of person completing form:_____ Date: _____

I understand that by completing this form, health information may be shared with District staff in order to ensure the health and safety of the student while at school or on school-provided transportation

STUDENT HEALTH HISTORY

Champaign Unit 4 School District recognizes the important role of your child's health and physical well-being in the learning environment. Please take a few minutes to complete this brief health survey.

	(Circle Yes or No)	
1. Has your child been diagnosed with asthma?	Yes	No
• Is your student currently being treated for asthma?	Yes*	No
2. Does your child have allergies?	Yes*	No
Allergic to_____		
Reaction_____		
Does your child require an EpiPen?	Yes*	No
3. Has your child been diagnosed with epilepsy or a seizure disorder?	Yes	No
• Is your student currently being treated for epilepsy or seizures?	Yes*	No
4. Does your child have diabetes?	Yes*	No
5. Does your child have sickle cell or history of a crisis?	Yes*	No
• Is your student currently being treated for sickle cell?	Yes*	No

****** If you answered yes to any of the questions above, please ask for and complete an action plan or medical management plan!******

6. Does your child have any physical disabilities or limitations? Yes No
If yes, please explain:

7. Does your child need to take medications during school hours? Yes***** No
If yes, please have the "Permit for Authorized Personnel to Administer/Distribute Medication During School Hours" form completed and returned to school office.

8. Are there any other concerns about your child's health at school you would like us to know about? Yes No
If yes, please explain: