

Rantoul Township High School
Allergy & Health History form

9 10 11 12

2016-2017

Student's Last Name, First Name _____

Grade _____

SEVERE ALLERGIES

BEE STING: Yes ___ No ___ Reaction _____ Treatment _____

PEANUT/NUT: Yes ___ No ___ Reaction _____ Treatment _____

FOOD: Yes ___ No ___ Food _____ Reaction _____ Treatment _____

MEDICATION: Yes ___ No ___ Drug _____ Reaction _____ Treatment _____

OTHER ALLERGIES: _____ Reaction _____ Treatment _____

* **The school does not provide medication.** If your child has a severe allergy that requires an Epi-Pen, please send their **Epi-pen to school.** If your child requires Benadryl, or an Epi-pen following a severe allergic reaction, a **physician's written order** and **parent/guardian's written consent is required to be on file.** Please remember to provide the school with the necessary medication(s).

Due to the Health Insurance Portability and Accountability Act (HIPAA) law, we request that parents/guardians inform teacher(s), school staff, and transportation staff of health conditions that could affect your child during the school day.

Please check the health conditions that apply to your child and list treatments or medications taken for the health condition(s).

Health Problem	Yes	No	Treatment	Health Problem	Yes	No	Treatment
Arthritis/Rheumatic Disease				Diabetes-Type-1			
Asthma				Diabetes-Type-2			
Attention Deficit Disorder/hyperactivity				Eating Disorder			
Bleeding disorders/ Anemia				Epilepsy/ Seizure Disorders			
Cardiovascular conditions				Sickle cell disease			
Cerebral Palsy				Spina Bifida			
Cystic Fibrosis				Tourettes Syndrome			

Other health problems _____

_____ My Child has no medical conditions, allergies or special needs at this time. I will notify the school if something should occur that needs special consideration.

*This information will be kept confidential unless an emergency arises, or the nurse determines that the school team, transportation staff, or primary care provider have a need to know because of a specific health concern regarding your child. I give consent to share this information with the school team, transportation staff, and primary care provider if an emergency occurs or the nurse determines there is a need to know to ensure the health, safety, and well-being of your child. I understand that it's my (parent's/guardian's) responsibility to inform teacher(s), school staff, and transportation staff of my child's health conditions.

Parent/Guardian's Signature _____ Date _____