Rantoul Township High School
Allergy & Health History Form

9 10 11 12 20 - 20

Student's Last Name, First Name Grade

SEVERE ALLERGIES

BEE STINGS: Yes___ No___ **Reaction**_____ **Treatment**_____
PEANUT/NUT: Yes___ No___ **Reaction**_____ **Treatment**_____

FOOD: Yes___ No___ **Reaction**_____ **Treatment**_____
MEDICATION: Yes___ No___ **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 Health Insurance Portability and Accountability Act (HIPAA) law, we request that parents/guardians inform teachers(s), school staff, and transportation staff of health conditions that could affect your child during the school day.

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No				
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature Date		
Bone/Joint problem/injury/scoliosis?	Yes No				

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 that 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:** _____