



## Student Medical Information 2021 – 2022

This form must be updated and returned to school each school year.

Please let your school know about your child’s health and health care. This is a good way to keep your child safe. The information is **CONFIDENTIAL** and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Student ID Number \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

**1. Please indicate your child’s health status below**

- My child has no known health conditions*
- My Child has a known condition(s). Please check all that apply:
- Allergies (food or other) – please specify:* \_\_\_\_\_
- Asthma* *Year Diagnosed* \_\_\_\_\_
- Diabetes – please circle one:*    *Type 1*            *Type 2*    *Year Diagnosed* \_\_\_\_\_
- Seizures/Epilepsy* *Year Diagnosed* \_\_\_\_\_
- Sickle Cell Disease* *Year Diagnosed* \_\_\_\_\_
- Other:* \_\_\_\_\_ *Year Diagnosed* \_\_\_\_\_

2. My child has a primary doctor.	YES	NO
-----------------------------------	-----	----

*If yes, please provide the healthcare provider’s name and phone number:*

*Name:* \_\_\_\_\_ *Phone number:* \_\_\_\_\_

*I give permission for my child’s school nurse or designee to talk to the doctor about my child’s health.*

3. My child is covered by health insurance.	YES	NO
---	-----	----

**If your child needs health insurance call Healthy CPS 773-553-KIDS (5437)**

This Form is **NOT** the same as a “**Plan of Care**” (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a “Medical Plan of Care Form” at: [www.cps.edu/oshw](http://www.cps.edu/oshw) (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

Parent Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Must have an original signature; an electronic signature is not acceptable.

**PLEASE RETURN THE FORM TO THE SCHOOL NURSE**

**IF THE STUDENT HAS A HEALTH CONDITION PARENTS MUST SCHEDULE A MEETING WITH THE SCHOOL NURSE**

<p><b>Nurses Use Only</b></p> <p>Reviewed by:</p> <p>Date and Initial</p>
---