Chronic Disease Information Form
Health Information

Student's Name_____Date of Birth_____ School Year_____
Teacher/ Homeroom_____School_____

This form must be completed annually. The parent or guardian is responsible for keeping the school informed of any changes in your child's medical condition. Information will be shared with appropriate school staff for your child's best care.

____ *My Child does not have a medical condition*

List medical conditions your child has NOW	***List all medicines your child takes NOW (home and school)***	***List any medication(s) to be given at school. A medication authorization form is required.***
ADD____ ADHD_____		
A2___ ALLERGY –INSECTS		*___Epipen*
A4____ALLERGY -MEDICATIONS *Name the medication*		*___ Epipen*
A5 ____ALLERGY –LATEX		*___Epipen*
A7____ALLERGY –FOOD *List the food.* *Physician order is needed for special diet.*		*___Epipen*
A9 ____ALLERGY –OTHER *Specify the allergy*		*___Epipen*
AS____ ASTHMA *How frequent are the episodes?*		*___ Inhaler at school* *___Inhaler at home* *___Nebulizer at home* *___Nebulizer at school*
CA____CANCER		
CP____CEREBRAL PALSY		
CYF____CYSTIC FIBROSIS		
DB____DIABETES *Hypoglycemia or Hyperglycemia*		*____ diet____oral medication* *____insulin____pump* *____carb counting*
EA____Ear problems(describe)		*____Hearing aide (Left/Right/Both)* *____FM System* *____Deaf (Left/Right/Both)*
EP ____EPILEPSY/SEIZURES *List known triggers*		*Last seizure_____*
GA____Gastrointestinal *____Reflux____IBS____Crohn's* *____Other*		
HD____HEART DISEASE *HM____HEART MURMUR*		
HE____HEMOPHILIA		

HP____HYPERTENSION		
KD ____KIDNEY DISEASE		
MD____MUSCULAR DYSTROPHY		
MG____MIGRAINES		
NO____NOSEBLEEDS *Occasional____Frequent____* *Medical condition____*		
PC____PSYCHIATRIC CONDITIONS *(Please list)*		
SC____SICKLE CELL ANEMIA *____Trait only*		*Last Crisis? _____*
VP____VISION PROBLEMS *Describe_____* *_____*		*____Glasses____Contacts* *____Visually Impaired* *____Blind (Left/Right/Both)*
Any medical condition not covered above, please list.		

Will any medication be taken at school for any of the illnesses listed above? ____Yes_____No
If yes, Dr._____Dr.'s Phone #_____
*******Medication cannot be given at the school until an authorization form is completed.***

Does your child use any adaptive equipment? Wheelchair ____ Walker_____ Braces_____
Other____(Specify)_____

********The Health Room Staff will be contacting you to set up a Care Conference for certain conditions listed above.***

Please print clearly persons to call in case of emergency

1st_____Phone(H)_____Cell_____

2nd_____Phone(H)_____Cell_____

_____Date_____
Parent or Guardian Signature

PCDSB FORM: #8330-F3
Revised April 2014