Central DeWitt Community School District

Student Health Summary – to be completed by parent/guardian

This information is confidential, but may be shared with appropriate school personnel when necessary

Student Name ____Date of Birth _____________Grade_______

Allergies: Please list allergies and describe severity of reaction

Environmental/Seasonal ____

Bee Sting allergy ____

Medication Allergy ____

Food Allergies ____

Epi-Pen prescribed? _______Yes _______No

Asthma _______Yes _______No

If Yes, will your child require an inhaler at school? _______Yes _______No

Diabetes _______ Yes _______No

Heart Condition _______Yes _______No

If Yes, name of condition and any activity restriction required____

____

ADHD/ADD _______Yes _______No

Diagnosed with Anxiety or Depression _______Yes _______No

Glasses/Contacts _______ Yes _______No

Hearing/Speech Concerns _______Yes _______No

Headaches/Migraines _______Yes _______No

Head Injury/Concussions _______Yes _______No

If yes, when and how____

____

Epilepsy/Seizures _______Yes _______No

Surgeries or serious injuries/Illness _______Yes _______No

If Yes, please describe and list date/age when occurred ____

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____

Other Health Conditions or Concerns ____

____

____

Please list medications taken regularly at home or school and specify frequency and reason for use

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*Medications taken at school (over-the-counter and prescription) need to be in the original labeled container and parent authorization forms need to be complete. The prescriber's written authorization is required for prescription medications, including inhalers and Epi-Pens.

Parent Signature ____Date____________