



Cleveland Heights – University Heights City Schools Student Health Update

To better serve the needs of your child, please assist us in updating your child's health status by providing the following information:

STUDENT NAME: _____ (_____)
ID- SCHOOL USE

Date of Birth: _____ **Grade:** _____ **Teacher's Name:** _____

MEDICAL CONDITIONS: (check all that apply)

() none () diabetes () ADHD () seizures () other: _____
please specify

() asthma: How is it controlled? _____

ALLERGIES: (check all that apply; where applicable, include medications used to treat a reaction)

() none () bee/insect sting (explain reaction): _____

() food: _____
please include all food allergies, type of reaction(s), and any classroom treat restrictions

() other allergies: (please explain): _____

ANY SURGERIES, HOSPITALIZATIONS, SERIOUS INJURIES OR ILLNESS?

() no () yes _____
please explain

EMOTIONAL/BEHAVIORAL: Does your child have any emotional / behavioral health concerns?

() no () yes: _____
please explain

MEDICATIONS: Does your child take medication for any reason?

() no () yes: _____
please specify medications, including when and why they are taken

Will your child need to take any of these medications during school hours? _____

VISION: Does your child wear glasses or contacts?

() no () yes, but glasses are lost/broken () yes, wears glasses () yes, wears contacts

HEARING: Does your child have any hearing problems? () no () yes: _____

PLEASE NOTE: THE ABOVE INFORMATION WILL BE SHARED WITH MEDICAL PROVIDERS IN THE EVENT OF AN EMERGENCY

PARENT / GUARDIAN SIGNATURE

DATE

Phone: Home: _____ Work: _____ Cell: _____

**** PLEASE RETURN THIS FORM TO THE SCHOOL AS SOON AS POSSIBLE ****