Chicago Public Schools

Office of Student Health and Wellness
42 West Madison • Chicago, Illinois 60602
Telephone: 773-553-3520 • Fax: 773-553-1883

Office Use Only
Reviewed by: _____
Follow up: _____
Documents received: _____

Student Medical Information 2015/2016 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED **ANNUALLY** AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Student ID: _____ Medicaid Number: _____

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

- ☐ Food Allergies: (Type) _____
- ☐ Other Allergies: (Type) _____
- ☐ Asthma
- ☐ Diabetes: Type 1 ☐ Type 2 ☐
- ☐ Seizures
- ☐ Other Medical Condition

  _____

  _____
- ☐ My child has **NO** allergies, medical conditions and/or does not take any medications during school hours
- ☐ My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a **504 Accommodation Plan** due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

Parent Name: (Please Print): _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____