



## Student Health Disclosure 2023-2024

*Providing your child's health and health care is a great way to keep your child safe.  
This information is CONFIDENTIAL and will be shared only with faculty and staff who need to know.*

Student Last Name	First Name	Middle Name
Gender	Date of Birth	Grade

Does your child have any known health conditions?

☐ Yes ☐ No

**Please check all that apply:**

☐ Allergies (food or other) - List Allergies: \_\_\_\_\_

☐ Asthma - Year Diagnosed: \_\_\_\_\_

☐ Seizures/Epilepsy - Year Diagnosed: \_\_\_\_\_

☐ Sickle Cell Disease - Year Diagnosed: \_\_\_\_\_

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other - Year Diagnosed: \_\_\_\_\_

☐ Other Medical Condition: \_\_\_\_\_ Year Diagnosed: \_\_\_\_\_

Please provide the information for your student's primary care doctor:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*Additional forms are required if your child has asthma (Asthma Action Form) and/or a food allergy (Illinois Food Allergy Form). The school office and your classroom teacher must be provided with any necessary medication for your student, including Benadryl or EpiPens.*

Parent Name

Phone Number

Parent Signature

Date