

**BARRINGTON PUBLIC SCHOOLS  
HEALTH INFORMATION**

The following information is needed for your child's health record

NAME \_\_\_\_\_ GRADE \_\_\_\_\_ TELEPHONE \_\_\_\_\_ SCHOOL \_\_\_\_\_

ADDRESS \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ PARENT(S) \_\_\_\_\_

CURRENT PHYSICIAN \_\_\_\_\_ BIRTH WEIGHT \_\_\_\_\_

DISEASES/CONDITIONS							
	Yes	No	Date		Yes	No	Date
ADHD				Heart Condition			
Asthma				Mononucleosis			
Chicken Pox				Operations			
Diabetes				Pneumonia			
Ear Infections				Seizure Disorder			
PE Tubes				Serious Accident			
Eczema				Serious Illness			
Headache/ Migraines				Strep Infections			

Does your child have any other physical or psychological condition of which the school should be aware? If Yes, explain.

\_\_\_\_\_

\_\_\_\_\_

Does your child have a health condition(s) which may require EMERGENCY ACTION while he/she is at school? Yes\_\_ No \_\_ If Yes, explain:

\_\_\_\_\_

\_\_\_\_\_

If your child has an **ALLERGY**, explain:

\_\_\_\_\_

\_\_\_\_\_

Does your child have a hearing problem? \_\_\_\_ Does your child wear glasses? \_\_\_\_

MEDICATION: Is your child on medication? Yes\_\_ No\_\_

Name of medication \_\_\_\_\_ Reason \_\_\_\_\_

DATE \_\_\_\_\_ PARENT'S SIGNATURE \_\_\_\_\_

HEALTH INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF