Springer
School and Center

FOR OFFICE USE ONLY – DISTRIBUTION:
□ School Office
□ Main Office
□ Homerooom: _____
□ Asst. Principal, if applicable

Please check Yes or No to the following questions*

CHRONIC ILLNESS/ALLERGY INFORMATION

***** If Prescription Medication is required during school hours, a separate form must be completed by the parent/guardian and physician*****

Student's Name: _____Department:_____ DOB: _____

- **ADD/ADHD** ☐ Yes ☐ No (if yes–>) **Medication at School?** ☐ Yes ☐ No
- **CHRONIC ILLNESS?** ☐ Yes ☐ No (if yes–>) **Emergency Medication at School?** ☐ Yes ☐ No

  (Including, but not limited to Anxiety Disorder/s, Diabetes, Epilepsy, Seizure Disorders, etc.)

  - Please Describe: _____
  - Precautions/Treatments during school hours: _____

    _____

- **ASTHMATIC?** ☐ Yes ☐ No (if yes–>) **Inhaler Provided to School?** ☐ Yes ☐ No
  - Asthma Triggers: _____
- **ALLERGY?** ☐Yes ☐ No (if yes–>) **Allergy Medication Provided to School?** ☐ Yes ☐ No
  - SPECIFIC ALLERGY TO: _____
  - Allergy is: ☐ Moderate ☐ Severe ☐ Seasonal
  - Past reactions due to: ☐ Ingestion ☐ Touch ☐ Airborne

An Individual Health Care Plan will be discussed and developed for any student with a life threatening allergy or illness.

General Care Summary:

- If your child felt unwell, would he/she seek help? ☐ Yes ☐ No
- If no, please comment on the barriers to communication:

  _____

  _____

- Is there any other information you feel would be helpful for us to know about you child?

  _____

  _____

Parent/Guardian Signature _____ **Date** _____