Chicago Public Schools

Office of Student Health and Wellness
42 West Madison • Chicago, Illinois 60602
Telephone: 773-553-3560 • Fax: 773-553-1883

Office Use Only
Received by: _____
Reviewed by:
Followed up by: _____

Student Medical Information 2018 – 2019

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is **CONFIDENTIAL** and will be shared only with CPS staff who need to know (Nurse, Principal or Designee, and Clerk).

_____ _____ _____
Student Name Date of Birth Student ID Number

_____ _____
School Grade

Circle yes/no and answer questions below.

1. My child has a primary healthcare provider.	YES	NO

If yes, please provide the healthcare provider's name and phone number:

*Name:*_____ *Phone number:* _____

☐ *I give permission for my child's school nurse or designee to talk to the healthcare provider about my child's health.*

2. My child is covered by health insurance.	YES	NO

*If yes, please circle type: Medicaid Private Other:*_____

3. My child has a health condition.	YES	NO

Please check all that apply:

☐ *Allergies (food or other) – please specify:* _____
☐ *Asthma*
☐ *Diabetes – please circle one: Type 1 Type 2*
☐ *Seizures/Epilepsy*
☐ *Other:* _____

This Form is **NOT** the same as a "**Plan of Care**" (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please let us know what is best to do. Complete a "Medical Plan of Care Form" at: www.cps.edu/oshw (or get it from the school nurse),and return it to school. ***If the problem is asthma or allergies, please complete Asthma Action Plan and Food Substitution Plan in this Packet.***

Parent Name: _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____

Revised March 18, 2018