

**District 428 Afterschool Program
Child Health/Special Information
(Please complete a separate form for each child)**

Child's Name _____

Parent's/Guardian's Name _____

_____ **No**, my child **DOES NOT** have a medical /health condition. (Simply sign below and return.)

_____ **Yes**, my child **DOES** have a medical/health condition. (Please complete this form.)

_____ **Yes**, my child **DOES** have Special Needs, a disabling condition, an IEP, or a 504 plan.

DIABETES **YES** _____ **NO** _____

1. Medication _____

ASTHMA **YES** _____ **NO** _____

1. Medication _____

ALLERGIES (may include foods) **YES** _____ **NO** _____

1. What causes an allergic reaction: _____

2. What are the symptoms of the reaction: _____

3. Medication _____

SEIZURES **YES** _____ **NO** _____

1. Type of seizure _____

2. Date of last seizure _____

3. Medication _____

HEART CONDITION **YES** _____ **NO** _____

1. Describe the condition _____

2. Describe any activity restriction _____

3. Medication _____

SPECIAL DIET **YES** _____ **NO** _____

Please describe _____

SPECIAL NEEDS or OTHER HEALTH CONCERNS THAT WE SHOULD KNOW ABOUT

(May include disabling conditions, ADD/ADHD, depression, bipolar, orthopedic conditions, etc. Use reverse if needed.)

REGULAR MEDICATION(S) OR PRESCRIPTIONS

Morning _____

Afternoon _____

By signing this form you give permission for the School Nurse and other school personnel to share health information and discuss this health/special needs condition as necessary.

Parent/Guardian signature

Date