HEALTH RECORD FORM

Student's Name_____

Northern Illinois University, Lorado Taft Campus
(815) 732-2111, extension 120

School_____

My child will attend the Lorado Taft Field Campus from _____to_____

Date of Birth _____ Age_____ Weight _____ Male____ Female____ Home Phone_____

Address_____
Street City State Zip

Name of Parent or Guardian_____ Father's work phone_____

Guardian's work phone_____ Mother's work phone_____

Alternate Contact name and number _____

Our family physician is _____Physician's phone_____

The answers to these questions will be kept confidential. The purpose of these questions is to provide our nurse with health and safety information about your child.

IMPORTANT - Please fill in date of last **TETANUS BOOSTER**_____

1. **See back of this form if child has asthma or doctor's excuse from PE activities.**

2. Is your child presently under a doctor's care? ____Yes ____No

3. Medical information the Taft nurse or emergency medical personell should know about. (allergy, illness, physical disability, sleep walker, bedwetter, etc.)

_____

4. **SPECIAL DIET** (vegetarian, diabetic, food allergies, etc.)_____

5. **MEDICATIONS** - *I hereby give permission for my child to take medication at Lorado Taft Field Campus under the supervision of authorized personnel, in accordance with Illinois State Board of Education Guidelines and Arlington Heights School Board Policy 7:270.* All medication, including prescription and non-prescription (over-the-counter) medication must have a written prescription by a licensed Physician and parental consent. All medication must be brought in a container appropriately labeled by a pharmacy or manufacturer and clearly marked with the child's name and instructions for administering. *IF YOUR CHILD IS PUT ON MEDICATION AFTER THE HEALTH FORM IS TURNED IN—SUBMIT PROPER FORMS TO THE NURSE IN YOUR SCHOOL.*

PLEASE LIST Medication(s)	Directions for administering (specify am or pm)	
_____	_____	am ☐ pm ☐
_____	_____	am ☐ pm ☐
_____	_____	am ☐ pm ☐

Self-Administering emergency medication:
Students with emergency-use inhalers, epi-pens and glucagon injections must carry them at all times.

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I give permission to have my child treated by the Lorado Taft Campus nurse, or by a physician in case of an emergency.

Signature of parent or guardian_____ **Date**_____

HEATH RECORD FORM IS DUE BACK TO HOMEROOM BY

SCHOOL MEDICATION AUTHORIZATION FORM
OUTDOOR EDUCATION FIELD TRIP – LORADO TAFT FIELD CAMPUS

NAME: _____ GRADE: _____

IF child is EXCUSED from PE for any reason, YOUR PHYSICIAN NEEDS to fill out, sign this release. MD initials X _____
Name _____ has my permission to participate in outdoor education.
Any limitations must be listed below:

_____

_____

ASTHMA/INHALER SECTION

Medication/Inhaler _____ Dosage _____ q _____ Hours

Neb Treatment – Name/Medication _____ Dosage _____ q _____ Hours

ASTHMA ACTION PLAN Peak flow meter – My Personal Best = _____

Green Zone – Breathing is easy, can play, work without symptoms **PEAK Flow Range 80%-100% of Personal Best**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

Yellow Zone – Breathing easy, coughing or wheeze, chest tight, SOB **PEAK Flow Range 50%-80% of Personal Best**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____

Red Zone – Medicine NOT working, nose open wide to breath, breathing is hard and fast, trouble walking and talking, ribs show
IF SYMPTOMS DO NOT GET BETTER – CALL 911 **PEAK Flow Range below 50%**
Medication/Nebulizer _____ Dose _____ Freq _____ Hours _____