ABINGTON HEIGHTS SCHOOL DISTRICT
Health Data

To: Parent or Guardian
From: School Health Services

Information provided on this form will enable school personnel to deal most effectively with your child's health problem(s) and allow him/her to receive the maximum benefits from his/her educational experience.

School: _____ Grade: _____ Date: _____

Student's Name: _____ Birth Date: _____ Male / Female

Address: _____

Father's Name: _____
Last First
Mother's Name: _____
Last First

Guardian (if other than parent): _____

Does your child have health insurance coverage? Yes / No

1. Has your child had Chicken Pox (Disease)? Yes / No Date: _____

   Has your child had the Varicella vaccine? Yes/ No Date: _____
2. Has your child ever had an allergic reaction to any medication? Yes / No
   If Yes, Name of medication: _____
3. Is your child allergic to **BEE / WASP STINGS**? Yes / No
   Please describe reaction: _____
4. Is your child allergic to specific foods? Yes / No
   If Yes, type of food: _____
   Please describe reaction: _____
5. Does your child have any difficulty with hearing? Yes / No
6. Does your child have any difficulty with vision? Yes / No
7. Is there anything more about your child's health that you think is important for the school to know? Yes / No Please indicate the nature of the condition:
   _____
   _____

8. **May the information in questions 3 through 7 be shared with other school personnel, as necessary for the health of your child? Yes / No**

Date: _____ Signature of Parent/Guardian: _____

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