Student Medical Information 2024 - 2025

Chicago Public Schools

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, Designee, or Clerk).

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F / M / X / N)	STUDENT DATE OF BIRTH	SCHOOL NAME

STUDENT ID #	GRADE	ROOM #

1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

☐ **YES** ☐ **NO**

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

☐ Allergies (food or other)

List Allergies: _____

☐ Asthma

Year Diagnosed _____

☐ Seizures/Epilepsy

Year Diagnosed _____

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other

Year Diagnosed _____

☐ Sickle Cell Disease

Year Diagnosed _____

☐ Other _____ Year Diagnosed _____

2. MY CHILD HAS A PRIMARY DOCTOR ☐ 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 doctor about my child's health.**

3. MY CHILD IS COVERED BY HEALTH INSURANCE: ☐ YES ☐ NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437).

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 provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a "Medical Plan of Care Form" at cps.edu/oshw (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.

_____ **Parent/Guardian Name**

_____ **Date**

_____ **Phone Number**

_____ **Parent/Guardian Signature**

_____ **Email**

Must have an original signature.
An electronic signature is not acceptable.

Nurses Use Only **Reviewed by (Initials)** _____ **Date** _____

Revised February 2024

THE FORM IS STORED IN THE STUDENT'S HEALTH RECORD