Grant Community High School District 124

HEALTH EMERGENCY FORM

Name of Student:	Grade:	Date:

Indicate YES or NO to all that apply with details:

ALLERGIES?	ASTHMA?
CONCUSSION?	MENTAL HEALTH CONDITION(S)?
DIABETES?	GASTROINTESTINAL CONDITION(S)?
HEARING PROBLEMS?	CHRONIC HEART CONDITION(S)?
MIGRAINES?	ORTHOPEDIC CONDITION(S)
SEIZURE DISORDER?	OTHER?

MEDICATIONS: ____

HISTORY OF SERIOUS INJURY/ ILLNESS/ HOSPITALIZATIONS /SURGERY? YES ______ NO ______. If yes, please explain:

____

____

____

____

____

____

EMERGENCY CONTACT PROCEDURE

HOSPITAL CHOICE- Please check <u>one</u> choice for a <u>non-life threatening</u> emergency:

ADVOCATE CONDELL _____ VISTA ______LAKE FOREST _____CENTEGRA MCHENRY ______ OTHER? ____________________

If a parent, legal guardian or the emergency contact person provided cannot be reached, a school official may assume the responsibility of arranging transportation for your child/ward to a medical facility. I give my permission for my child/ward to receive medical care deemed necessary by an attending physician. I also give my permission for the release of my child's/ward medical records and/or information from our physician/health care provider to the Health Services at Grant Community High School. This includes the Certificate of Child Health Examination, immunizations records and health history.

____ ______________________________________

Parent/Guardian Signature Date