

MEDICAL QUESTIONNAIRE

2011 – 2012

Student Name: _____ Grade: _____

Condition 1: **Glasses?** Y N
If yes, are the glasses worn full time? _____

Condition 2: **Medical Hearing Problems?** Y N
If yes, please explain: _____

Special instructions? _____

Condition 3: **Diabetes*?** Y N
If yes, please explain: _____

*If yes, the school will be contacting you to develop a diabetes management plan, as required by Illinois law.

Condition 4: **Anaphylaxis Danger/Use of EpiPen/Food Allergy/Other life-threatening allergic reactions**?** Y N
If yes, please explain: _____

**If yes, the school will be contacting you to develop an allergy management plan.

Condition 5: **Other allergies?** Y N
If yes, please explain: _____

Special instructions? _____

Condition 6: **Daily Medication(s)?** Y N
If yes, please list: _____

Special instructions? _____

Over, please 

Condition 7: **Other Medical Condition?** Y N

If yes, please explain: _____

Physician: _____

Hospital/ER: _____

Physician Phone #: _____

Hospital/ER Phone: _____

Medicaid Number (if applicable): ____ _
(9 – Digit Number)

Date: _____

Signature: _____
(Parent/Guardian)