13801 South Chatham Avenue
Blue Island, IL 60406
Phone: 708.206.0000
Fax: 708.957.5324

ALTERNATIVE ACADEMIC ACHIEVEMENT ACADEMY
CONFIDENTIAL HEALTH QUESTIONNAIRE

STUDENT'S NAME _____

ROOM NO. _____ AGE _____ GRADE _____

In order to better serve your child's educational and health needs, the following information is requested to keep your child's health records current. This information will only be shared with appropriate staff.

Does your child have a health history of the following:

	YES	NO	COMMENTS
ASTHMA			
ALLERGIES*			
EPI PENS			
SEIZURES			
HEART DISEASE			
EAR INFECTIONS			
HEARING			
DIABETES			
ADHD			
SURGICAL HISTORY			
MEDICATIONS **			
OTHER			

Does your child wear: GLASSES _____ CONTACT LENSES _____

(Please check) For: Constant Wear ____
Distance ____
Reading only ____
Close work ____

*Doctor's note required.
** If your child needs to receive medication during the school day, a permission form **must** be signed by prescriber and parent/guardian.

_____ _____
Signature of Parent/Guardian Date

"All Children Are Worth Saving"

Office Use: Nurse Verified___/___/___