Student Medical History Form

Chicago Public Schools

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible.

please print or type:

STUDENT NAME

STUDENT'S DATE OF LAST EYE EXAM

SCHOOL NAME

DOES YOUR CHILD CURRENTLY WEAR GLASSES/CONTACTS? ☐ YES ☐ NO

HOW DID YOU FIND OUT ABOUT THE VISION PROGRAM? (Check all that apply)

☐ School Staff ☐ Failed Vision Screening Letter ☐ Friend ☐ Other

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

☐ Asthma ☐ Behavioral problems ☐ Attention Deficit Disorder ☐ Glaucoma ☐ Neurological problems

☐ Endocrine problems ☐ High Blood Pressure ☐ Musculoskeletal problems ☐ Heart Disease ☐ Mental Health illness

☐ Gastrointestinal problems ☐ Genitourinary problems ☐ Hearing/Ear problems ☐ Diabetes ☐ Other Condition _____

IS YOUR CHILD TAKING ANY MEDICATIONS? ☐ YES ☐ NO

List Medications

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO

List Allergies

DOES YOUR CHILD USE EYE DROPS? ☐ YES ☐ NO

List Eye Drops

HAS YOUR CHILD EVER HAD EYE SURGERY? ☐ YES ☐ NO

If yes, please explain

HAVE THEY HAD ANY OF THE FOLLOWING?

☐ Vision Therapy ☐ Blurred/Double Vision ☐ Tearing/Watering ☐ Difficulty sitting still ☐ Frustrates easily

☐ Eye patch ☐ Loses place while reading ☐ Light sensitivity ☐ Avoids reading/writing ☐ Lack of confidence

☐ Eye Surgery ☐ Eye Injury ☐ Redness ☐ Difficulty paying attention ☐ Eye Discharge

☐ Pain in eyes ☐ Eye Infection ☐ Drooping Lid ☐ Reads below grade level ☐ Lazy/Wandering Eye

☐ Difficulty Tracking ☐ Itching/Burning ☐ Trouble finishing work ☐ Poor handwriting

☐ Other _____

DOES YOUR CHILD'S IMMEDIATE FAMILY MEMBER HAVE ANY OF THE FOLLOWING? (Check all that apply and the relationship to child)

YES ☐ NO ☐ Wears glasses YES ☐ NO ☐ Glaucoma YES ☐ NO ☐ Lazy eye YES ☐ NO ☐ High Blood Pressure

YES ☐ NO ☐ Blindness YES ☐ NO ☐ Macular Degeneration YES ☐ NO ☐ Diabetes YES ☐ NO ☐ Wandering Eye

YES ☐ NO ☐ Heart Disease YES ☐ NO ☐ Cardiovascular problems YES ☐ NO ☐ Neurological problems YES ☐ NO ☐ Mental Health illness

YES ☐ NO ☐ Musculoskeletal problems

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan)? ☐ YES ☐ NO

IS YOUR CHILD PERFORMING AT: ☐ Above grade level ☐ Grade level ☐ Below grade level

IF BELOW GRADE LEVEL, PLEASE SELECT THE CLASS (Check all that apply) ☐ Reading ☐ Math ☐ Social Studies ☐ Writing ☐ Other _____

IS THE CHILD CURRENTLY RECEIVING ANY OF THE SERVICES BELOW?

☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

LIST ANY OF YOUR CHILD'S HOBBIES OR SPECIAL INTERESTS:

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD?