# 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?**