



Student Health Inventory

School Year: _____

Student Name: _____ School: _____ Grade: _____
 Birthdate: ___/___/___ Male Female Best phone # during school hours: () _____
 Medical Insurance? Private Medi-Cal CalOptima Emergency Medi-Cal None
 Primary Doctor's Name/City: _____
 Medical Specialists: (List Names/Specialty) _____

Dental Insurance: Yes No Vision Insurance: Yes No

Has your child had any problems with?

	Yes	No	Explain any "Yes" responses: (more space below if needed)
Allergies: Life threatening? EpiPen needed at School? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Food(List) _____ <input type="checkbox"/> Insect bites (List): _____ <input type="checkbox"/> Medication. (List): _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Latex <input type="checkbox"/> Other (List): _____ Reaction (Explain): _____
Allergies: Non-Life threatening?			<input type="checkbox"/> Food(List) _____ <input type="checkbox"/> Insect bites (List): _____ <input type="checkbox"/> Medication. (List): _____ <input type="checkbox"/> Seasonal <input type="checkbox"/> Latex <input type="checkbox"/> Other (List): _____ Reaction (Explain): _____
<input type="checkbox"/> ADD <input type="checkbox"/> ADHD Date of Diagnosis: _____ By Whom: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Severe Date of Diagnosis: _____ By Whom: _____			Last episode: _____ Triggers: _____ Inhaler at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Nebulizer at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Autism: Date of Diagnosis: _____ By Whom: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Blood Disorder: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Special precautions needed at school:
Bone/Joint Problems Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Explain:
Brain injury: <input type="checkbox"/> Acquired <input type="checkbox"/> Traumatic			Date of injury: _____ Explain:
Cancer: Type:			<input type="checkbox"/> Current <input type="checkbox"/> Past <input type="checkbox"/> Remission <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Central line
Cerebral Palsy			<input type="checkbox"/> Upper extremities <input type="checkbox"/> Lower extremities <input type="checkbox"/> Right <input type="checkbox"/> Left
Cystic Fibrosis			
Developmental Delay			
Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II			<input type="checkbox"/> Insulin injections at school* <input type="checkbox"/> Insulin Pump* <input type="checkbox"/> Oral medication
Down Syndrome			
Ear Infections-frequent			PE tubes <input type="checkbox"/> Current <input type="checkbox"/> Past
Endocrine Disorder: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Fainting/Blackouts, frequent Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Last episode: _____ Triggers:
Gastrointestinal Disorder			Explain:
Genetic Disorder			Explain:
<input type="checkbox"/> Head Injuries <input type="checkbox"/> Concussions			How many? _____ Age/s: _____ How did they occur?
Hearing Loss Date of last hearing test:			If yes: <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear Hearing aids: <input type="checkbox"/> Right <input type="checkbox"/> Left Cochlear Implant: <input type="checkbox"/> Right <input type="checkbox"/> Left



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	Yes	No	Explain any "Yes" responses: (more space below if needed)
Heart Condition Under doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			Explain:
Immune Disorder			Explain:
Kidney/Bladder Condition			Explain:
Lung Condition			Explain:
Mental Health Condition: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Other: (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Date of Diagnosis: _____ By Whom:
<input type="checkbox"/> Migraine <input type="checkbox"/> Headaches			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Neurological Condition			Explain:
Neuromuscular Condition			Explain:
Nose Bleeds-frequent			
Seizures/Epilepsy: List seizure type: _____ Date of last seizure: _____			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No Diastat: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Skin Condition (Explain)			Medication at: Home: <input type="checkbox"/> Yes <input type="checkbox"/> No School: <input type="checkbox"/> Yes* <input type="checkbox"/> No
Vision Problems			<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Night-only Contacts Patching: <input type="checkbox"/> Right <input type="checkbox"/> Left
Activity Restrictions: Do any of these conditions affect the student's ability to participate in routine school activities, programs or PE?			If yes, provide a note from the healthcare provider indicating the restrictions or special needs and how long they will be needed.
Medical Procedures/Equipment (List)			At: <input type="checkbox"/> Home <input type="checkbox"/> School* If needed at school, you will be contacted for further information.
Medication: List <u>all</u> DAILY medication:			
<u>Medication/Purpose</u>			<u>Dose/Frequency</u>
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
_____			<input type="checkbox"/> Home <input type="checkbox"/> School*
*Contact the school health office for <u>ANY</u> Medication or Medical Procedures to be given or done during school hours.			
Any serious medical condition not listed above? Explain:			
Any "yes" answer above that requires more explanation:			
Please provide any additional information that might impact this student's education or safety:			

No current known Medical Problems.

The above information may be shared with appropriate school staff to ensure the student's health and safety at school. It is the parent/guardian responsibility to inform the school health office of any changes in this student's health status.

Signature of Parent/Guardian: _____ **Date:** _____
 Relationship: _____