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

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	Yes	No	**Explain any "Yes" responses:** (more space below if needed)
Heart Condition Under doctor's care? ☐Yes ☐No			Explain:
Inmune Disorder			Explain:
Kidney/Bladder Condition			Explain:
Lung Condition			Explain:
Mental Health Condition: ☐ **Anxiety** ☐ **Depression** ☐ **Bipolar** **Other:** (Explain)			Medication at: Home: ☐Yes ☐No School: ☐Yes* ☐No Date of Diagnosis: _____ By Whom:
☐**Migraine** ☐**Headaches**			Medication at: Home: ☐Yes ☐No School: ☐Yes* ☐No
Neurological Condition			Explain:
Neuromuscular Condition			Explain:
Nose Bleeds-frequent			
Seizures/Epilepsy: List seizure type: _____ Date of last seizure: _____			Medication at: Home: ☐Yes ☐No School: ☐Yes* ☐No Diastat: Home: ☐Yes ☐No School: ☐Yes* ☐No
Skin Condition (Explain)			Medication at: Home: ☐ Yes ☐ No School: ☐ Yes* ☐ No
Vision Problems			☐Glasses ☐Contacts ☐Night-only Contacts Patching: ☐ Right ☐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 (Please list equipment)			At: ☐ Home ☐ School* If needed at school, you will be contacted for further information.

Medication: **List <u>all</u> DAILY medication:**

Medication/Purpose	Dose/Frequency	
_____	_____	☐ Home ☐ School*
_____	_____	☐ Home ☐ School*
_____	_____	☐ Home ☐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:

☐ <u>No current known Medical Problems.</u>

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: _____