

Academy Health Inventory



Information provided through this form will be used to assess any health needs your child may have during the school day. School staff may contact parent(s)/guardian(s) for further clarification or relevant health information. Please notify school when there are significant changes to your child's health or medical needs.

Child Name: _____		Date of Birth: _____		Age: _____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Grade: _____		Previous School/District Attended: _____					
Medical Insurance: <input type="checkbox"/> Private Insurance		<input type="checkbox"/> CHP+		<input type="checkbox"/> Medicaid		<input type="checkbox"/> Uninsured	
Form completed by: _____							
		Name (Print)		Relationship to child		Date	
Home Phone: _____		Work Phone: _____		Cell: _____			

MEDICAL DIAGNOSES:

Check ALL that apply:	Diagnosed by:	Diagnosis date:
AD/HD <i>Type:</i> _____	Provider:	Date:
Allergies: <i>Type: Mild Moderate Severe</i> <i>If yes, to what:</i> _____	Provider:	Date:
Asthma/Respiratory	Provider:	Date:
Autism	Provider:	Date:
Communicable Disease: <i>If yes, please list</i>	Provider:	Date:
Diabetes <input type="checkbox"/> <i>Type I</i> <input type="checkbox"/> <i>Type II</i>	Provider:	Date:
Enuresis (Bedwetting)/Urinary Disorder	Provider:	Date:
Epilepsy/Seizure Disorder	Provider:	Date:
Headaches/Migraines	Provider:	Date:
Hearing Loss/Ear Infections	Provider:	Date:
Heart Condition	Provider:	Date:
Immune System Disorder	Provider:	Date:
Mental Disorder	Provider:	Date:
Neuro/Muscular Disorder	Provider:	Date:
Skin Conditions	Provider:	Date:
Stomach/Bowel Disorder/Encopresis (Soiling)	Provider:	Date:
Syndromes: <i>If yes, please list on</i>	Provider:	Date:
Traumatic Brain Injury	Provider:	Date:
Hospitalizations/Surgeries: <i>If yes, please list</i>	Provider:	Date:
Other		

Healthy Child- No concerns

MEDICATION(S)

Please list medications taken at home and school. If additional space required, please attach separate list.

The Academy requires both a written physician's order and written parent permission in order to administer medication and/or procedures at school for your child.

****Any student medications not being provided to the school will require a medication opt-out form. This includes inhaler, epi-pen, etc).****

Drug Name	Dosage	Time(s)	Reason

MEDICAL CARE REQUIRED AT SCHOOL

Please circle all that apply: GT feeding, nebulizer treatments, catheterization, oxygen, assisted oral feedings, toilet and diapering. Other (please list): _____

WELL CHILD CARE

Date of Last Physical Exam: _____ Physician's Name: _____

Date of Last Vision Exam: _____ Requires glasses/contacts: Yes No Concerns: _____

Date of Last Hearing Exam: _____ Hearing Loss? Yes No Hearing Aid? Yes No

Date of Last Dental Exam: _____

Any other vision/hearing/dental concerns: _____

LIFESTYLE

Nutrition Appetite: Good Fair Poor Concerns: _____

Fitness Activity Level: Very Active Active Quiet

Describe types of exercise: _____
(i.e. organized sports, riding bikes, running, playing outside, etc.)

Sleep Bedtime @ _____ Wakes up @ _____ Concerns: _____

Pre-K through Grade 5 (Optional)

BIRTH HISTORY

Early history not known

Prenatal Care: Yes No

Pregnancy was: Normal Complicated, _____
Explain any conditions (i.e. toxemia, infection, pre-mature labor, smoking, drugs, etc.)

Length of pregnancy: _____ Type of Delivery: (*Circle*) Vaginal C-Section Forceps/Suction

Labor/Delivery was: Normal Complicated, _____
Explain (i.e. required oxygen, breech, chord around neck, bleeding, etc.)

Birth weight: _____ Describe any newborn complications: _____
Explain (i.e. jaundice, required oxygen, intensive care, etc.)

Length of hospital stay: Mother _____ Infant _____

DEVELOPMENTAL HISTORY

Early history not known

Age: Crawled @ _____ Walked @ _____ First words @ _____ Weaned to cup @ _____

Fed self finger foods @ _____ Toilet trained @: Bowel _____ Bladder _____

Was there any early childhood concerns about your child: _____
(i.e. speech, language, motor, developmental, etc.)

Any additional concerns: _____

Parent Signature: _____ Date: _____