MOUNT PLEASANT CENTRAL SCHOOL DISTRICT
STUDENT HEALTH INVENTORY FORM

Student Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date(s):**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies: ☐ food ☐ latex ☐ environmental ☐ bee ☐ insect ☐medication ☐ other ___________	☐	☐	Reaction___________________________________ ☐ Epipen ☐ Benadryl ☐ Other ____________
Been hospitalized	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces	☐	☐	
Been diagnosed with COVID-19	☐	☐	
Been hospitalized with COVID-19	☐	☐	
Has lab confirmed COVID-19 antibodies	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

☐ ADHD ☐ Asthma ☐ Autism Spectrum Disorder ☐ Bedwetting ☐ Blood Disorder ☐ Dental Injuries ☐ Diabetes	☐ Ear Infections ☐ Fainting ☐ GI Conditions (Ulcer, Reflux, IBS) ☐ Headaches/Migraines ☐ Heart Conditions ☐ High Blood Pressure ☐ Inflammatory Disease	☐ Mental Health Condition (Depression, Eating Disorder, Anxiety, OCD, ODD etc.) ☐ Nosebleeds (frequent) ☐ Nosebleeds (requiring medical treatment)	☐ Scoliosis ☐ Single Organ (☐Kidney, ☐ Testicle) ☐ Skin Condition ☐ Speech Condition ☐ Thyroid Disease ☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list Name, Dose, Time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐ Crutches ☐ Walker ☐ Wheelchair ☐ Other: ___________________
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐ Insulin/Blood Glucose Monitoring ☐Special Diet ☐ Inhaler/Nebulizer/Peak Flow Monitoring

Is there any condition that would prevent your child from participating in Physical Education/Sports or would require modification to participate?

☐ No ☐Yes:____

Please list additional concerns: (use the back of sheet if necessary)____

Parent/Guardian Signature: ____ Date: _______________