



2022-23 Annual Health Inventory

THIS IS A REQUIRED FORM TO BE COMPLETED EVERY SCHOOL YEAR. IT IS DUE THE FIRST DAY OF SCHOOL.

Turlock Unified School District

Child's Name: _____ Birth Date: _____ Age: _____

School: _____ Grade: _____ Teacher: _____ Date: _____

Is your child under the care of a medical specialist (i.e., ear doctor, allergist, orthodontist or psychologist)? YES NO

If YES, please explain: _____

Has your child had a physical exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor:	Exam Date:
Has your child had an eye exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Doctor:	Exam Date:
Does your child wear glasses or contact lenses at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	For Near, Far, At all times (circle one)	Exam Date:
Has your child had a dental exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentist	Exam Date:
Does your child have a hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wears hearing aids <input type="checkbox"/> Yes <input type="checkbox"/> No	Audiologist	Exam Date:
Has your child had an operation and/or serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify:	

HEALTH CONCERNS – LIFE THREATENING HEALTH CONDITIONS

If a life threatening health condition exists, a medication/treatment order from a Licensed Health Professional must be provided to your child's school prior to his/her attendance. If a health condition exists, an Emergency Care Plan may be developed by the District School Nurse.

My child **DOES NOT** have any health concerns.

If there are health concerns, check all that apply:

ASTHMA Rescue Inhaler: Yes No Date last used: _____ Triggers? _____

ALLERGIES Localized Severe (Anaphylactic)

ALLERGY TYPE: Food Medication Stinging Insect Latex Environmental Other _____

List Allergies: _____ Treatment: _____

DIABETES: Type 1 Type 2 Managed by: Diet only Oral meds Insulin injections Insulin pump

SEIZURE DISORDER Type of seizure: _____ Date of last seizure _____ Diastat: Yes No Lorazepam: Yes No Other: _____

CANCER/BLOOD DISORDER: Please specify: _____

ANOREXIA OR BULIMIA KIDNEY DISEASE ADD/ADHD AUTISM FREQUENT NOSEBLEEDS FREQUENT HEADACHES

FREQUENT STOMACH ACHES HEPATITIS HEART CONDITION/DISEASE RHEUMATIC FEVER SERIOUS HEAD INJURY

OTHER HEALTH CONCERNS

Please explain any items that you have checked: _____

Does your child have any other condition that might affect learning? _____

Does your child have a condition that requires special consideration in the classroom or for physical education? _____

Has there been any traumatic event in your family within the past 12 months that would affect your child's school experience adversely? _____

MEDICATIONS

Prior to any medication given at school, a written authorization is required from a Licensed Health Professional and parent/legal guardian. **An Authorization for Administration of Medication form is available from the school office or on the district web site home page under Parent and Student, Student Health, Student Medication Administration Forms.**

Is medication needed at home? Yes No If yes, name of medication and condition _____

Is medication needed at school? Yes No If yes, name of medication and condition _____

In the event of an emergency that requires medical treatment and/or hospitalization, the school is authorized to contact 911 and/or:

Doctor Name: _____ Doctor Address: _____ Doctor Telephone: _____

Parent Telephone: _____ Emergency Contact Telephone: _____

My signature grants permission for the school nurse to contact/discuss/review information regarding my child's medical care with the healthcare provider.

Signature Parent/Guardian: _____ Date: _____

	Name/Relationship	Phone Number
Contact #1:		
Contact #2:		
Contact #3:		