SAN MATEO UNION HIGH SCHOOL DISTRICT

9th Graders and New Incoming Students*

STUDENT HEALTH INVENTORY

Name_____ Grade_____ Birthdate _____ Sex [ ] M [ ] F

Address _____ Phone (_____) _____

PLEASE CIRCLE YES OR NO:

WEARS GLASSES: YES NO
CONTACT LENSES: YES NO
HEARING LOSS: YES NO
WEARS HEARING AID: YES NO

MY CHILD HAS THE FOLLOWING HEALTH CONDITION(S):
(PLEASE CHECK AND EXPLAIN BELOW IF NECESSARY)

[ ] ALLERGIES (list): _____

[ ] ANAPHYLACTIC REACTION TO: _____

*MEDICATIONS: [ ] EPI-PEN® [ ] Other medication for anaphylaxis: _____

[ ] ASTHMA *LIST INHALER(S): _____

[ ] DIABETES, *INSULIN DEPENDENT: _____

[ ] EPILEPSY/SEIZURE DISORDER: _____

[ ] HEART CONDITION (please circle A or B)

A. NO RESTRICTIONS

B. RESTRICTIONS (EXPLAIN): _____

[ ] MIGRAINES: treatment: _____

OTHER *SIGNIFICANT* PHYSICAL OR EMOTIONAL HEALTH CONDITION(S):

_____

_____

_____

IF MY CHILD HAS SYMPTOMS OF THE ABOVE CONDITION, PLEASE TAKE THE FOLLOWING ACTION AT SCHOOL:

_____

_____

_____

NAME OF MEDICATIONS TAKEN: _____

_____

NAME OF MEDICATIONS WHICH MUST BE TAKEN DURING SCHOOL HOURS/*MEDICATION AUTHORIZATION FORM REQUIRED:

_____

*** Is the student trained and considered physically, mentally, and behaviorally capable by his/her physician and you to self-administer medication?: *Please Circle* Yes *No *If "no" call the Health Office for further instructions.**

Date: _____ **Signed: _____**
Parent/Guardian

**Annual health information on Emergency Card*

Form #143 Rev. 1/2009