BISHOP CISD HEALTH INVENTORY

NAME: _____ **GRADE:** _____
Last First Middle

ADDRESS: _____
Number Street City Zip Code

DATE OF BIRTH: _____ **AGE:** _____
Month/Day/Year

Parent 1/Guardian Name: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Parent 2/Guardian Name: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

IF PARENT CANNOT BE REACHED, PLEASE INDICATE ALTERNATE ADULT(S) WHOM THE SCHOOL SHOULD CALL:

_____
Alternate Adult Relationship Phone Number

_____
Alternate Adult Relationship Phone Number

Education Code 21.031 (g) and (h)
A person who knowingly falsifies information of a form required for enrollment of a student in a school district is liable for the greater of the maximum tuition fee or the amount the district has budgeted for each student as maintenance and operation expenses if the student is not eligible for enrollment in the district but is enrolled on the basis of this false information.

PHYSICIAN: _____ PHONE NUMBER: _____
DENTIST: _____ PHONE NUMBER: _____

Check those illnesses that this student has had and/or those health condition(s) of which the school should be aware. Give dates, if possible, when the illness(es) occurred.

Asthma	Yes__ No__ Date_____	Does the student have a vision problem?	Yes___ No___
Chicken Pox	Yes__ No__ Date_____	If Yes, state the vision problem:	_____
Diabetes	Yes__ No__ Date_____	Does the student wear glasses?	Yes___ No___
Epilepsy or Seizures	Yes__ No__ Date_____	Does the student wear contacts?	Yes___ No___
Heart Condition	Yes__ No__ Date_____	Does the student have hearing loss?	Yes___ No___
Heart Surgery	Yes__ No__ Date_____	Does the student wear hearing aids?	Yes___ No___
Neurological Problems	Yes__ No__ Date_____		
Orthopedic Problems	Yes__ No__ Date_____		
Nosebleeds	Yes__ No__ Date_____		

Does the student have allergic reactions to any drug, food, or insect bites? Yes____ No____
If Yes:
Name of Drug: _____
Name of Food: _____
Name of Insect: _____

What is a typical reaction and treatment? _____

Does the student take medication on a regular basis? Yes____ No____
If yes, name the medication: _____
Additional health problems or instructions not previously covered: _____

Parent/ Guardian Signature: _____ **Date:** _____