Turlock Unified School District

2026-27 Annual Health Inventory

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

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

Physician Name: _____ Physician Address:_____ Physician 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		