CRESCENT SCHOOL DISTRICT

Student Health Inventory

Date _____

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the school nurse.

Name _____ Birthdate _____ Grade _____ M/F
Last First Middle

Is student under a doctor's or orthodontist's care? Yes _____ No _____
If yes, please explain _____

Does student have:

Allergies? Yes_____ No_____ To food, animals, drugs? Please list_____
Has the allergy required emergency action in the past? Yes_____ No_____
Needs emergency medication? Yes_____ No_____
List medication_____

Bee sting allergy? Yes_____ No_____ Describe reaction_____
Difficulty breathing? Yes_____ No_____
Needs emergency medication Yes_____ No_____
List medication_____

Asthma? Yes_____ No_____ Triggered by:_____
List medication if any_____

Diabetes? Yes_____ No_____ Takes insulin? Yes_____ No_____

Epilepsy/Seizures Yes_____ No____ Describe seizure_____
Date of last seizure_____ Medication Yes_____ No_____
List medication if any_____
Is student under a doctor's care for seizures? Yes_____ No_____

Heart condition? Yes_____ No_____ Describe_____
Any physical restrictions?_____
Medication? Yes_____ No_____ List medication_____

Kidney/Bladder Yes_____ No_____ Chronic infections? Yes_____ No_____ Wets/soils pants? Yes_____ No_____
or Bowel problems? List medication, if any_____

Mental or Yes_____ No_____ Depression_____ Eating Disorder_____ Excessive worry or anxiety_____
Emotional problems? Phobias_____ Violent behavior_____ Behavior disorder_____
List medication_____
Currently under doctor's/counselor's care? Yes_____ No_____

Has your child fainted or passed out during or after exercise, emotion or startle? Yes_____ No_____

Has your child had extreme fatigue, unusual shortness of breath, discomfort, pain, or pressure in chest during exercise? Yes_____ No_____

Has your child ever been diagnosed with unexplained seizure disorder? Yes_____ No_____

(Please continue on back side of page)

Are there any family members who have had unexplained fainting or seizures? Yes_____ No_____

Does your family have any family members who had an unexplained death or who died of heart problems before the age of 50? (Include SIDS and accidents) Yes_____ No _____

Please explain any "Yes" answers _____

_____

_____

Check off the following health concerns that pertain to your student:
Eyes: Glasses? Yes_____ No_____ Contacts? Yes_____ No_____
For Reading_____ Distance_____ Other_____

Ears: Hearing difficulty? Yes_____ No_____ Explain_____
Tubes? Yes_____ No_____
Hearing aid(s)? Yes_____ No_____ Right?_____ Left?_____ Wears at school? Yes_____ No_____

Other: Severe stomach pain/ulcers? Yes_____ No_____ Frequent severe headaches? Yes_____ No_____
Cancer? Yes_____ No_____ Blood disorder? Yes_____ No_____ Bone/joint? Yes_____ No_____
ADD/ADHD? Yes_____ No_____ Requires catheterization? Yes_____ No_____
Requires diapering? Yes_____ No_____ Nosebleeds? Yes_____ No_____ Skin? Yes_____ No_____
Bedwetting? Yes_____ No_____

Has student had chicken pox? Yes_____ No_____ Has student had chicken pox vaccination? Yes_____ No_____

List serious illness or injuries_____

Surgeries (operations) _____

Any condition(s) that PREVENTS PE participation? (require doctor's note)_____

Daily medication at home? Yes_____ No_____ At school? Yes_____ No_____ Emergency only? Yes_____ No_____

Name of medication(s) and reason for taking_____

Special education or services? Yes_____ No_____ Explain_____

Requires special health care? Explain_____

If student requires medication at school, please obtain the appropriate form from the school office.

_____

Signature of legal parent/guardian Home/work phone Date

H/office/health/studenthealthinventory