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

Does student have private health insurance? Yes No Medicaid? No Yes ID# ____________________

Doctor's name ______________________________ Last physical exam/year ____________________
Phone

Dentist's name ______________________________ Last exam/year ____________________
Phone

Is student under an orthodontist's care? Yes No Orthodontist's name ______________________________
Phone

Does student have: (Code)

Allergies? A 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? A10 Yes No Describe reaction ____________________
Difficulty breathing? Yes No Need emergency medication? Yes No
List medication ____________________

Asthma? B Yes No Triggered by: ____________________

Diagnosed by doctor: ____________________ Date: __________

Diabetes? D Yes No Takes insulin? Yes No Date diagnosed ____________________

Epilepsy/Seizures? F Yes No Describe seizure ____________________

Date of last seizure ______________ Medication ______________
Is student currently under a doctor's care for seizures? Yes No

Heart condition? C Yes No Describe ____________________

Any physical restriction? ____________________
Medication? Yes No

Kidney/Bladder or Bowel problem? K Yes No Chronic infections? Yes No Wets/soils pants? Yes No
List medication ____________________

Mental or Emotional problems Yes No Depression R60 Eating disorder Excessive worry or anxiety
Phobias Violent behavior Behavior disorder R40
List medication ____________________
Currently under doctor's/counselor's care? Yes No

CRESCENT SCHOOL DISTRICT
Student Health Inventory (page 2)

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

Has your child has 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_____

Does your child 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_____

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

Please explain and "yes" answers____
____
____
____

Check off the following health concerns that pertain to student:

Eyes: glasses/EG or contacts/EC for reading ___ distance___ other__________________

Ears: hearing difficulty? Yes No Explain __________________
Tubes? Yes No Hearing aid? H20 Right Left wears at school? Yes No

Other:

Severe stomach pain/ulcers P66	frequent/severe headaches P46	severe head injury/concussion F14
Cancer N99	Blood disorder C98	Bone/joint
ADD/ADHD R20	Requires catheterization K18	Requires diapering
Nosebleeds	Skin	Menstruation
Bedwetting		

Has student had chicken pox? Yes ______ No ______
Has student had the chicken pox vaccination? Yes ______ No ______

List serious illness or injuries __________________

Surgeries (operations) __________________ Condition that **PREVENTS** PE participation __________________
Date

Daily medication at home? Yes No At school? Yes No Emergency only? Yes No
Name medication 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 in the school office.

____
Signature of legal parent/guardian Home/work phone Date