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