Grade___________________

Teacher_________________

Appleton City
Student Health Inventory

To assist in providing health services at school please complete all questions and return to school tomorrow.

Student Name____
Last First Middle

Male ____ Female ____ Birthdate _____________________ Home Phone # ________________________

Address _______________________________________ City__________________ Zip ______________

Father's Name ________________________________Father's Employment ________________________

Father's Work Phone ___________________________ Father's Cell # _____________________________

Mother's Name _________________________________ Mother's Employment ____________________

Mother's Work Phone ___________________________ Mother's Cell #____________________________

Emergency Contacts: Name __________________________ Phone # ____________________________

Name __________________________ Phone # ____________________________

Name __________________________ Phone # ____________________________

Doctor's Name ______________________________________ Phone # ____________________________

Date of Last Physical Exam ____________________________

Dentist's Name _____________________________________ Phone # ___________________________

Date of Last Exam ___________________________________

Is your child under an orthodontist's care ____ If yes, name of dentist ____________________________

Does the student have: Private Health Insurance Yes _______ No _____ ___

Medicaid Yes ____ No _____ DCN # ______________________________________

MC+ Yes ___ No ___ # _______________ Name of Plan ____________________

Does your child have any of the following health conditions?

Allergies: Yes ___ No ___ to drugs, food, insects, bee stings, seasonal, etc.? Please list all below:

____

Has the allergy required emergency treatment in the past? Yes ____No ____

Please describe reaction: ____

____

Asthma: Yes ___ No ___ does it treatment while at school? Yes ___ No ____ (please note that all Inhalers used during school hours and all school related activities must be accompanied by physician's paperwork that may be obtained in the school nurse's office.)

Diabetes: Yes ___ No ___ does your child do daily blood glucose monitoring? Yes ______ No _______

Takes Insulin? Yes _____ No _____

Seizures: Yes ___ No ____Date of last seizure ____
Is student currently under a doctor's care for a seizure disorder? Yes___ No___

Heart Condition: Yes___ No ___ Describe condition ____
Is student currently under a doctor's care for a heart condition? Yes___ No___

Bone or Joint Problem: Yes ___ No ___ Describe condition ____________________________________
Is student currently under a doctor's care for a bone or joint problem? Yes___ No___

Eyes: Glasses ___(reading___distance___) Contacts____ Crossed___Lazy eye___Difficulty Seeing_____

Ears: Frequent Infections___Tubes___Difficulty Hearing(explain)________________________________
Hearing aid: ___Right___Left-Does student wear during school hours? Yes___ No___ Other_________

Other Concerns: ___Nosebleeds ___Eating ___Sleeping ___ Bowel___ Requires Diapering? Yes__ No__
___ Skin ___Bladder ___Requires Catheterization? Yes___ No___ Bedwetting_______
___Dental ___ Blood Disorder ___Neurological___ Lungs___ Headaches____________
___Menstruation ___Phobias(Fears)___ ADD____ ADHD ____Blood Pressure Concerns

Please list any previous serious childhood diseases, illnesses, injuries and surgeries:
____
____

Please list any health conditions that prevent participation in any type of physical activity (A doctor's note is required): ____

My child requires specialized health care while at school: (Explain)______________________________

My child requires a special diet while at school: (Explain) ______________________________________

Please list any other health information or concerns the nurse should be aware of: _______________

____

My child takes daily medication: Yes______ No______ At school? _____ At home? ________________

Type of Medication? ____

My child may take over-the-counter medications as determined by the school nurse while at school.

Yes ____ No _____ Please list the specific medications your child may take while at school: (Example: Tylenol, Tums, cough drops, etc.). ____

____

________________________________ ____________________________
Parent/Guardian Signature (required) Date

<u>Note: If a student requires an inhaler, a P.E. restriction, special diet, or specialized healthcare procedures while at school, please obtain the appropriate form from the school nurse.</u>