Health Inventory

School_____ Date_____

Teacher_____ Grade_____

Dear Parent:
Please complete this form and return it to the office/school nurse. The information will enable the school nurse and staff to have better understanding of the health of your child.

Student Full Legal Name_____Gender_____DOB_____

Medication Allergies_____Food Allergies_____

Please check any of the following signs and symptoms you have recently observed:

Frequent headaches_____Frequent stomachaches_____Frequent earaches_____
Frequent sore throats_____Frequent nosebleeds_____Vomiting_____
Frequent sinus problems_____Environmental allergies_____Fainting_____
Have you consulted a doctor about the symptoms you have observed? Yes_____NO_____

Medical History – please check all that apply to your child

Asthma_____Age_____Diabetes_____Age_____Chickenpox_____Month_____Year_____
Allergies_____Age_____Heart disease_____Age_____Fractures_____Age_____
Seizures_____Age_____Kidney disorder_____Age_____Serious injury_____Age_____
Hearing loss_____Age_____Vision loss_____Age_____Glasses_____yes_____no_____

Please give additional information on the above marked conditions_____
_____

Current Medications_____

Is he/she under the treatment of a doctor at this time? Yes_____No_____
For what condition(s)?_____

Name of physician/clinic_____

List names of brothers/sisters and please include ages_____

***If you child has any serious condition that might impact his/her school activities, please notify the school nurse.

Has your child attended Lone Oak schools before? Yes/No Year_____Grade_____

Parent/Guardian signature_____Date_____