

**EAST VALLEY SCHOOL DISTRICT #361  
HEALTH INVENTORY**

STUDENT NAME \_\_\_\_\_ GENDER M  F

BIRTHDATE \_\_\_\_\_ PARENT/GUARDIAN \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_

Please check your child's current and past health concerns. Briefly describe the concern. If the concern is in the past, indicate the date.

Office Use Only
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- Allergy    Mild \_\_\_\_\_    Life Threatening \_\_\_\_\_
  - Food \_\_\_\_\_
  - Type of Reaction \_\_\_\_\_ Treatment \_\_\_\_\_
  - Bee Sting \_\_\_\_\_ Type of Reaction \_\_\_\_\_
  - Treatment \_\_\_\_\_
  - Medication \_\_\_\_\_ Type of Reaction \_\_\_\_\_
  - Treatment \_\_\_\_\_
  - Other \_\_\_\_\_
- Asthma \_\_\_\_\_
- Heart Conditions \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Seizures Type \_\_\_\_\_ Date of Last Seizure \_\_\_\_\_
- Hearing Problem/Chronic Ear Infections \_\_\_\_\_
- Blood Disorder \_\_\_\_\_
- Orthopedic Condition \_\_\_\_\_
- Kidney/Bladder Condition \_\_\_\_\_
- Stomach/Intestinal/Eating Disorder \_\_\_\_\_
- ADD/ADHD/Behavior \_\_\_\_\_
- Mental Health Concerns \_\_\_\_\_
- Head Injury: Date \_\_\_\_\_ Headaches: Type \_\_\_\_\_
- Neurological Condition \_\_\_\_\_
- Cancer \_\_\_\_\_
- Skin Conditions \_\_\_\_\_
- Vision Concerns/Glasses \_\_\_\_\_

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Are there any other health problems of which the school should be aware?    Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: \_\_\_\_\_

Has your child had previous surgery/hospitalization?    Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: \_\_\_\_\_

Does your child require medication on a regular basis (at home or at school?)    Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please specify: \_\_\_\_\_

I give permission for this information to be released to school personnel on a need-to-know basis for the health and safety of my child.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date