

# East Valley School District #361

## Health Inventory

The information provided will be reviewed by a school nurse and may be shared with your child's teacher(s), the school secretaries, and any other school personnel who have a need to know in order to maintain safety at school. If you have any questions, please contact the school nurse.

Last Name:	First Name:	Gender:	M	F	Birthdate:	
School:	Teacher:			Grade:		
Parent/Guardian:	Home phone:	Cell Phone:				
Emergency Contact:	Home phone:	Cell Phone:				

**Section A: My child does not have any health concerns:**  (If checked skip to section B)

ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication:	<input type="checkbox"/> Medication at School
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	<input type="checkbox"/> Food Intolerance <input type="checkbox"/> EpiPen
Bee sting allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:	<input type="checkbox"/> Local reaction <input type="checkbox"/> EpiPen
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:	<input type="checkbox"/> Inhaler at school
Blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Developmental concern	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:	
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date/type last seizure:	
Gastrointestinal concern	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Heart condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Notes:	<input type="checkbox"/> Migraines
Mental health condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Musculoskeletal concern	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Urinary system concern	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:	

**Section B: Has your child had?**

Serious illness/injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type & date:
Concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cause & date:

**Section C: Does your child have?**

Wear glasses or contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wear hearing aid(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section D: Does your child?**

Have an IEP or 504 plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:
Have any medical or physical restrictions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Specify:
Ride a bus	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**A signed Doctor/Parent Permission Form is required for students needing medication at school. Please obtain necessary paperwork from the office.**

**Parent Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RN Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_