FLORIDA UNION FREE SCHOOL DISTRICT
HEALTH INVENTORY

Student's Name: _____ Sex: □**M** □**F** DOB: _____

Address: _____ Home Phone: _____

Mother's Name: _____ Father's Name: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Grade: _____ School: _____

Health History – Please mark all that apply. Explain "Comments" below if necessary.

Anemia		Asthma		Diabetes	
Convulsions / Seizures		Bronchitis		Ear Infections (more than 3 a year)	
Epilepsy		Bed Wetting		Sore or Strep Throats (more than 6 a year)	
Nose Bleeds		Pneumonia		Broken Bones	
Heart Disease		Chicken Pox		TB (in family or contact with TB)	
Sickle Cell Disease / Trait		Scarlet Fever		Rheumatic Fever	
Urinary Problems		Serious Burns		Lyme Disease	
Nephritis Infections		Lead Poisoning		Any Other Problems Not Listed Above	

Comments (please use additional sheet if necessary):

_____

_____

Has your child ever been hospitalized? □**Yes** □**No** Please list date and reason below:

_____

_____

Has your child ever had a visual exam? □**Yes** □ **No** Has your child ever had a hearing evaluation? □**Yes** □ **No**

Does your child wear glasses or a hearing aid? □**Yes** □ **No** Explain: _____

Does your child have a heart problem? □**Yes** □ **No**

If yes, please complete the following section:

□Heart murmur □Innocent □Grade (if known) _____ □Mitral Valve Prolapse □Extra heartbeat

Has your child ever had an EKG? □ **Yes** □ **No** Date/Dates: _____

Has your child ever had an Echocardiogram? □ **Yes** □ **No** Date/Dates: _____

Has your child seen a Cardiologist? □**Yes** □ **No** Date/Dates:_____

Doctors Name: _____ Telephone # _____

Has your child been released by the doctor for regular activities? □**Yes** □ **No**
If no, please explain below:

_____

_____

Is your child in the care of any of the following Health Care Professionals?

Specialty	Name/Phone Number of Specialist	Date Seen	Reason
Allergist			
Eye, Ear, Nose, Throat			
Orthopedist			
Psychiatrist			
Psychologist/Therapist			
Social Worker/Counselor			
Physical Therapist			
Occupational Therapist			
Neurologist			
Speech Pathologist			
Other			

Comments (please use additional sheet if necessary):

_____

_____

Does your child have any allergies (medicines, foods, bee stings, insect bites, environmental, other)? What happens when your child has an allergic reaction? Is medication needed in school to treat this allergy? If so please list the medication(s).

_____

_____

_____

Does your child have any chronic illnesses (asthma, reactive airways, other) or physical limitations? If so does this condition limit participation in Physical Education, Physical Activities or Recess?

_____

_____

Is your child on any medication? Please name the medicine and reason it is needed.

_____

_____

Is there any other information that the school should know in order to safeguard your child's health?

_____

_____

I understand that this confidential information will be shared with school personnel deemed appropriate by the health professional in charge

I hereby certify that all the information provided above is true and accurate to the best of my knowledge.

Please Print Parent/Guardian Name_____ Relationship to Child _____

Parent/Guardian Signature _____ Date _____