Henrietta Independent School District

Health Inventory Form

**** Please contact the school nurse to update this information as needed.**

Dear Parent/Guardian:

Please return the completed form to the school office. The information given will enable the school staff to have a better understanding of the health status of your child.

Student Name:	Birth Date:	Sex:
Address:	Grade:	Teacher:
Medication Allergies:	Food/Environmental Allergies:	

Medical History: (Please check all that apply, and give the date of initial diagnosis.)

Behavioral Conditions: **Date:**
- ☐ ADD / ADHD _____
- ☐ Anxiety /Panic Attacks _____
- ☐ Bipolar Disorder _____
- ☐ Depression _____
- ☐ Other: _____

_____

Brain: **Date:**
- ☐ Cerebral Palsy _____
- ☐ Seizure _____

Type:_____

Cardiac / Vascular: **Date:**
- ☐ Anemia _____
- ☐ Heart Disease _____
- ☐ Hemophilia _____
- ☐ Hypertension _____
- ☐ Leukemia _____
- ☐ Sickle Cell Trait _____
- ☐ Sickle Cell Disease _____

Communicable Diseases: **Date:**
- ☐ Chicken Pox Illness _____
- ☐ TB _____

Eyes / Ears / Nose: **Date:**
- ☐ Blindness _____
- ☐ Cataracts _____
- ☐ Color Blindness _____
- ☐ Detached Retina _____
- ☐ Strabismus _____
- ☐ Cochlear Implants _____
- ☐ Hearing Aide(s) L R _____
- ☐ Hearing Loss L R _____

Gastrointestinal: **Date:**
- ☐ Bowel "Problems" _____

_____
- ☐ Colitis _____
- ☐ Crohn's Disease _____
- ☐ Hepatitis – Type _____ _____
- ☐ Irritable Bowel Syndrome _____

Others not listed:_____

_____

_____

_____

Serious Accident:_____

_____

Orthopedic **Date:**
- ☐ Kyphosis (hump back) _____
- ☐ Lordosis (sway back) _____
- ☐ Muscular Dystrophy _____
- ☐ Scoliosis _____

Respiratory: **Date:**
- ☐ Asthma _____
- ☐ Cystic Fibrosis _____
- ☐ Allergy – Anaphylaxis _____
- ☐ Allergy – Seasonal Hayfever _____

Other: **Date:**
- ☐ Cancer _____

Type_____
- ☐ Diabetes Type 1 Type 2 _____
- ☐ Insulin Pump _____
- ☐ Lupus _____

Surgery: **Date:**

_____

_____

Urinary: **Date:**
- ☐ Kidney Disorder _____
- ☐ Urinary "Problems" _____

_____

Is your child currently receiving medical care? Yes or No. If yes, for what reason?

_____

Is your child currently on any medication(s)? Yes or No. If yes, please list.

_____

Signature of Parent/Guardian: _____ Date:_____

Home Phone ( )_____Work Phone ( )_____ Cell Phone ( )_____

Signature Parent/Guardian:_____ Date:_____

Home Phone ( )_____Work Phone ( )_____ Cell Phone ( )_____

IN THE EVENT THAT THE PARENT/GUARDIAN CANNOT BE REACHED, CALL:

Name_____Relationship_____Work Phone:_____Cell Phone_____

Name_____Relationship_____Work Phone:_____Cell Phone_____

Physician: _____ Office Phone:_____

Dentist: _____ Office Phone:_____