Henrietta Independent School District
Health Inventory

Dear Parent / Guardian:
Please return this 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 date of initial diagnosis.)

Behavior Problems:
- ☐ ADD/ADHD
- ☐ Depression

Brain:
- ☐ Cerebral Palsy
- ☐ Seizure Disorder

Cardiac / Vascular:
- ☐ Anemia
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Leukemia
- ☐ Rheumatic Fever
- ☐ Sickle Cell Trait
- ☐ Sickle Cell Disease

Communicable Diseases:
- ☐ Chicken Pox (DATE:)____________
- ☐ TB – Contact
- ☐ Others not listed:_________________________
____

Eyes/Ears/Nose/Throat:
- ☐ Blindness
- ☐ Cataracts
- ☐ Cochlear Implant
- ☐ Detached Retina
- ☐ Hearing Aid(s)
- ☐ Hearing Loss
- ☐ Strabismus
- ☐ Glaucoma

Gastrointestinal:
- ☐ Bowel "problems" __________
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis – Type _____
- ☐ Irritable Bowel Syndrome

Other:
- ☐ Cancer – Type:______________
____
- ☐ Surgery – Type_____________
____
- ☐ Serious Accident -___________
____

Orthopedic:
- ☐ Kyphosis (Hump Back)
- ☐ Lordosis (Sway Back)
- ☐ Muscular Dystrophy
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Fractures

Respiratory:
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ Allergy –Severe
- ☐ Allergy – Seasonal

- ☐ Kidney Disease
- ☐ Lupus
- ☐ Diabetes
- ☐ Insulin Pump

Is your child currently under medical care? ☐Yes or ☐ No. If yes, for what condition?
____

Is your child currently on any medications? ☐Yes or ☐ No. If yes, please list.
____

Signature of Parent/Guardian ____ **Date:**_____________________

Home Phone ( )__________________ **Work Phone ( )**__________________ **Cell Phone( )** __________________________

Signature of Parent/Guardian ____ **Date:**_____________________

Home Phone ( )__________________ **Work Phone ( )**__________________ **Cell Phone( )** __________________________

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

NAME:	RELATIONSHIP:	HOME PHONE:
		WORK PHONE:
NAME:	RELATIONSHIP:	HOME PHONE:
		WORK PHONE:
STUDENT PHYSICIAN:		OFFICE PHONE:
STUDENT DENTIST:		OFFICE PHONE:

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