

FORT ZUMWALT SCHOOL DISTRICT STUDENT HEALTH INVENTORY

Student: _____
Last
First
M.I.

School: _____ Grade: _____ Date of Birth: _____

Sex: M F

Check all that apply to your child:

<input type="checkbox"/> ADD / ADHD	Medication? <input type="checkbox"/> Specify Med: _____	
<input type="checkbox"/> Allergies, food	Epi Pen? <input type="checkbox"/> Specify Food: _____	***Additional forms required
<input type="checkbox"/> Allergies, insects	Epi Pen? <input type="checkbox"/> _____	***Additional forms required
<input type="checkbox"/> Allergic Reaction to Medications		
<input type="checkbox"/> Allergies, other	Specify: _____	
<input type="checkbox"/> Asthma:	Medication? <input type="checkbox"/> Specify Med: _____	***Additional forms required
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
<input type="checkbox"/> Diabetes - Please provide Dr. contact information:	***Additional forms required	
<input type="checkbox"/> Does your child use hearing aides or have a cochlear implant?		
Additional Information: _____		
<input type="checkbox"/> Does your child wear glasses or contacts?	Fulltime <input type="checkbox"/>	Just for reading <input type="checkbox"/>
Additional Information: _____		
<input type="checkbox"/> Epilepsy / seizures	Additional Information: _____	***Additional forms required
<input type="checkbox"/> Heart condition / disease	Additional Information: _____	
<input type="checkbox"/> Mental / emotional condition	Additional Information: _____	
Under care of mental health professional? <input type="checkbox"/> Name: _____		
<input type="checkbox"/> Migraines	Medication? <input type="checkbox"/> Specify Med: _____	Bring to school <input type="checkbox"/>
<input type="checkbox"/> Nosebleeds: (mild - moderate - severe)		
<input type="checkbox"/> Skin condition	Specify: _____	
<input type="checkbox"/> Orthopedic problems	Specify: _____	
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Leg braces <input type="checkbox"/> Walker		
<input type="checkbox"/> Other:	Specify: _____	

By signing this form, I give school personnel permission to treat my child for minor illness or injury while at school.

Ft. Zumwalt will provide routine vision and/or hearing screenings for all students in grades K – 5 and grade 7.

COMPLETE AND SIGN ON REVERSE SIDE

**District policy requires a doctor's signed, written request for administration of prescription medication.*

MEDICATIONS: taken at school? Please list:			<u>***Additional forms required</u>
1.			
2.			
MEDICATIONS: taken at home? Please list dosage and times:			
1.			
2.			
3.			
Has your child had a serious illness/hospitalization?			
Specify: _____			
Does your child need:			
<input type="checkbox"/> Restricted physical education (need Dr. note)			
<input type="checkbox"/> Special seating			
Other conditions the school should be aware of:			
1.			
2.			
3.			
Local Physician's name & telephone number			

Name	Address	Telephone	
<p><i>In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me I hereby authorize the school to take the steps necessary to insure the well being of the above-named child, which may include calling 911. If the parent(s)/guardian(s) cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parent(s)/guardian(s). This information is confidential and will be shared with school personnel when deemed necessary.</i></p> <p><i>NOTE: Please keep the office informed of current emergency contact information.</i></p>			
_____ Signature of Parent / Guardian (Required)		_____ Relationship	_____ Date

You will be requested to complete and update the Student Health Information form annually.