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:

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

- ☐ Restricted physical education (need Dr. note)
- ☐ Special seating

Other conditions the school should be aware of:

1.
2.
3.

Local Physician's name & telephone number

Name | Address | Telephone

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.

NOTE: Please keep the office informed of current emergency contact information.

Signature of Parent / Guardian (Required) | Relationship | Date

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