STUDENT HEALTH INVENTORY

Last Name: ____

First Name: ___________________________ Middle Name: _________________________

Date of Birth: ________/________/________ Student Gender: Male ☐ Female ☐

(Month) (Day) (Year)

Date of last:

____________________ ____________________ ____________________

physical exam dental exam last eye exam

Does your child:	**NO**	**YES (if yes, please explain)**
Take any medication at home?		
Have any allergies?		
Have any breathing difficulties/concerns? (Including asthma, reactive airway disease, etc.)		
Have any difficulty hearing or any ear issues? (including frequent ear infections or tubes in the ear)		
Have any difficulty seeing? (including use of glasses or contacts)		
Have any restrictions on physical activity?		
Have any speech difficulties?		

Health Conditions

Asthma ☐ Diabetes ☐ Heart ☐ Disease ☐ Seizures/Convulsions ☐

Has your child ever had chickenpox? ☐ Yes ☐ No When? ______________________

Hospitalizations (date/reason) ____

Other Medical
Conditions/concerns____

____ ______________________

Parent/Guardian Signature Date