

TOUTLE LAKE SCHOOL DISTRICT

STUDENT HEALTH INVENTORY

2005 - 2006

Student _____ Sex _____ Birth Date _____

Address _____ Phone _____

Father's Name _____ Work Place _____ Phone _____

Mother's Name _____ Work Place _____ Phone _____

Student Lives With _____ Relationship _____

Home Phone _____ Work Phone _____

Regular Physician or Clinic (if any) _____ Phone _____

DOES YOUR CHILD HAVE?

Allergies	No	Yes	Specify _____
Anorexia	No	Yes	Specify _____
Asthma	No	Yes	Specify _____
Blood Disorders	No	Yes	Specify _____
Cancer	No	Yes	Specify _____
Depression	No	Yes	Specify _____
Diabetes	No	Yes	Takes Insulin No <input type="checkbox"/> Yes <input type="checkbox"/>
Ear Infections	No	Yes	Date of Last Infection _____
Epilepsy or Seizures	No	Yes	Date of Last Seizure _____
Heart Condition	No	Yes	Specify _____
Insect/Bee Sting Allergy	No	Yes	Reaction Local <input type="checkbox"/> Systemic <input type="checkbox"/>
Kidney Disease	No	Yes	Specify _____
Migraines	No	Yes	Specify _____
Orthopedic Problems	No	Yes	Specify _____
Headaches	No	Yes	Specify _____
Nervousness	No	Yes	Specify _____
ADD or ADHD	No	Yes	Specify _____

HAS YOUR CHILD HAD?

A Serious Illness	No	Yes	Specify Type & Date _____
A Serious Injury	No	Yes	Specify Type & Date _____
Surgery (Operations)	No	Yes	Specify Type & Date _____

DOES YOUR CHILD HAVE

Trouble Seeing Close Work	No	Yes
Trouble Seeing At A Distance	No	Yes
Trouble Hearing	No	Yes

DOES YOUR CHILD

Wear Glasses	No	Yes
Wear Contacts	No	Yes
Wear Hearing Aides	No	Yes

Does your child have a condition, which prevents participation in regular P. E. (running, push-ups, wrestling, contact sports, etc.)? No Yes

Specify _____

Does he or she take daily medication? No Yes

Specify _____

Does your child need to have any medical or physical restrictions? No Yes

Specify _____

Does your child require any specific medical equipment/medical or nursing procedures at school?

Specify _____ No Yes

STATE AND SCHOOL DISTRICT REGULATIONS REQUIRE PHYSICIAN AND PARENT PERMISSION FOR TAKING MEDICATION AT SCHOOL.

Please obtain this permission form from the school office or health room.

IN THE EVENT OF AN EMERGENCY, (if the parents and/or authorized physician named on this inventory cannot be reached at the time of the emergency and immediate observation or treatment is urgent in the judgement of the school authorities) I AUTHORIZE AND DIRECT THE SCHOOL AUTHORITIES TO SEND THE PUPIL (PROPERLY ACCOMPANIED) TO THE HOSPITAL OR DOCTOR MOST EASILY ACCESSIBLE. I understand that I will assume full responsibility for the payment of any services rendered.

May Student receive blood products in case of emergency? No Yes

Signature of Parent/Guardian _____

Date _____