Student Health Inventory

Teacher___________________________ Grade_____________ School___________________________

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return this to the School Nurse.

Name____ Birthdate________________ Boy ☐ Girl ☐
Last First Middle

Parent/Guardian____ Phone #____________________

Parent's employment ______________________________ ______________________________
Father Phone Mother Phone

Emergency Contacts ______________________________ ______________________________
(Other than parent) Name Phone Name Phone

Last School attended____
Name City State

Doctor's name____ Date of last physical _____________

Dentist's name____ Date of last exam________________

Is student under an orthodontist's care? Yes ☐ No ☐ Doctor's name________________________________

Does student have:

Allergies? Yes ☐ No ☐ To drugs, food, insects, pollen? Please list_______________________
Has the allergy required emergency action in the past? Yes ☐ No ☐
Comments____

Bee sting allergy? Yes ☐ No ☐ Describe reaction ____________________________________
Difficult breathing? Yes ☐ No ☐ Need emergency medication? Yes ☐ No ☐

Asthma? Yes ☐ No ☐ Triggered by_________________ Treatment_______________
Diagnosed by doctor ____________________ Date__________

Diabetes? Yes ☐ No ☐ Takes insulin? Yes ☐ No ☐ Date Diagnosed_______________
Epilepsy/Seizures Yes ☐ No ☐ Describe seizure ____________________________________
Date of last seizure _______________ Medication_____________
Is student currently under a doctor's care for seizures? Yes ☐ No ☐

Heart condition? Yes ☐ No ☐ Describe ____
Any physical restrictions? _____________Medication? Yes ☐ No ☐

Bone or joint problems? Yes ☐ No ☐ Describe ____
Any physical restrictions? ______________________________

Check off the following regarding health concerns that pertain to student:

Eyes: Glasses ☐ Contacts ☐ Difficulty seeing
☐ Reading ☐ Crossed ☐ Lazy Eye
☐ Distance

Ears: ☐ Frequent Infections
☐ Tubes
☐ Hearing difficulty, explain

Hearing Aid
☐ Right ☐ Left
☐ Wear at School
☐ Other

Other: ☐ nosebleeds ☐ eating ☐ sleeping ☐ bladder ☐ skin ☐ phobias ☐ bedwetting
☐ lungs ☐ neurologic ☐ headaches ☐ bowel ☐ dental ☐ ADD/ADHD

Daily medication at home? Yes ☐ No ☐ At school? Yes ☐ No ☐ Emergency only? Yes ☐ No ☐
Name of medication and reason for taking____
List serious illness or injuries____
Surgeries (*operations*)______________________________ Condition that prevents PE participation________________
Other health information or concerns____

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.

The Camden County School Nurse program for non-public schools is administered by the Southern NJ Perinatal Cooperative.