BETHALTO SCHOOL HEALTH SERVICES
Student Health Inventory

Your child's learning depends upon good health. To assist us in providing health services at school, please complete the following form and return to your school nurse. **This information may be shared with staff as appropriate for the well being of your child.**

Name:_____ DOB: ____/____/____ Gender: Male Female
Last First Middle

Physician's Name:_____ Physician's Phone:_____ Date of last physical: _____

Dentist's Name: _____ Dentist's Phone: _____ Date of last exam: _____

Is your child under orthodontist's care? YES NO Orthodontist's Name:_____

Allergies to drugs, food, insects, pollen ? YES NO Please list: _____
Has the allergy required emergency action this past year? YES NO Comments:_____
Please circle: Mild Moderate Severe

Does your child have difficulty breathing? YES NO Comments:_____
Does your child need emergency medication? YES NO Type of medicine: _____

Does your child have asthma? YES NO
If yes, please submit an Asthma Action plan from the doctor to the School Nurse. Treatment: _____

Does your child have Diabetes? YES NO Date diagnosed: _____
Does your child take Insulin? YES NO

Does your child have epilepsy/seizures? YES NO Describe seizure: _____
Is your child under doctor's care for seizures? YES NO Date of last seizure:_____
Medication:_____

Does your child have a Heart Condition? YES NO Describe: _____
Does your child have Physical restrictions? YES NO Medication:_____

Does your child have bone or joint problems? YES NO Describe: _____
Any physical restrictions?: _____

Circle any of the following health concerns that pertain to your child:

Eyes:	Glasses/Contacts:	Reading / Distance	Difficulty Seeing	Crossed	Lazy Eye
Ears:	Tubes	Frequent Infections	Hearing Difficulty	Hearing Aid: Left Right	Wears aid at school
Other:	Nosebleeds	Eating	Sleeping	Bladder	Menstruation
	Lungs	Neurologic	Headaches	Bowels	Blood Disorder
	Phobias	ADD/ADHD	Dental	Bedwetting	Blood Pressure
	Skin Conditions	Requires Diapering	Requires Catheterization		

Daily medication at home? YES NO Name of medication and reason for taking:_____
_____
_____

Daily medication at school? YES NO Name of medication and reason for taking:_____
_____

Please Note: If your child requires medication at school, either prescribed as needed or over-the-counter, a medication form must be on file in the nurses office or if a change in physical education participation is required, please send the appropriate note from your physician.

List serious illness or injuries:_____
Surgeries (operations):_____
Condition that prevents PE participation:_____

Other health information concerns:_____
"Information pertinent to any communicable disease outbreak/diagnosis may be shared with the appropriate agency(s)"

If you would like information regarding State Health Insurance, offered by the State of Illinois, please contact your child's school nurse or www.allkids.com

_____
Signature of Parent/Guardian Date