

## Orange Unified School District Student Health Inventory

Date \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

Student Name \_\_\_\_\_ Male  Female   
Last First Middle

HEALTH STATUS	NO	YES	DESCRIBE IF YES	NO	YES
*Any changes since last school year?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____		
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal/Environmental <input type="checkbox"/> Mild <input type="checkbox"/> Severe <input type="checkbox"/> Allergic to: _____ Takes daily medication: <input type="checkbox"/> If yes, specify: _____ Has emergency medication: <input type="checkbox"/> **If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	Mild <input type="checkbox"/> Severe <input type="checkbox"/> Specify type and/or cause of asthma attack: _____ Takes daily medication: <input type="checkbox"/> If yes, specify: _____ Has emergency medication: <input type="checkbox"/> **If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
BEE STING ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	**Needs antihistamine if stung **Needs epinephrine injection if stung	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	Has received dental care Date of last dental exam: _____	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	Tests blood routinely Insulin injections <input type="checkbox"/> Glucagon injections <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/> Under doctor's care: <input type="checkbox"/> Date of last medical exam: _____	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	Takes daily medication If yes, specify: _____ Has emergency medication **If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	Under doctors care Specify restrictions at school: _____	<input type="checkbox"/>	<input type="checkbox"/>
ORTHOPEDIC PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	Under doctors care Specify any restrictions at school: _____	<input type="checkbox"/>	<input type="checkbox"/>
SERIOUS INJURY OR ILLNESS NOW OR IN PAST	<input type="checkbox"/>	<input type="checkbox"/>	Under doctors care Specify: _____ Takes daily medication If yes, specify: _____ Takes emergency medication **If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
SURGERY/OPERATIONS	<input type="checkbox"/>	<input type="checkbox"/>	Under doctors care If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
HAS HEALTH CONDITION WHICH PREVENTS PARTICIPATION IN REGULAR P.E.	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify condition and limitations: _____		
HAS TROUBLE SEEING	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with distance <input type="checkbox"/> Difficulty with near vision <input type="checkbox"/> Wears: glasses <input type="checkbox"/> contact lenses <input type="checkbox"/> Date of last visit with eye doctor _____		
HEARING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	Wears hearing aids: Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> Both <input type="checkbox"/> Under doctor's care: <input type="checkbox"/> If yes, date of last doctor's visit: _____	<input type="checkbox"/>	<input type="checkbox"/>
OTHER HEALTH PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	Specify problem: _____ Specify any needs at school: _____ List medications: _____		

\*Complete a new Student Health Inventory any time there are changes in your child's health.

\*\*Use of medication at school requires a signed Parent and Physician Request for Medication form, which is available at OrangeUSD.org or your child's school.