Health Inventory

Student's Name: _____ Birthdate: _____
Last First Middle

1. If your child has had any of the following, please check (✓) and give date where possible.

✓	Disease History	Date	✓	Disease History	Date
	Asthma			Hepatitis	
	Allergy*			Hyperactivity	
	Blood Disorder*			Kidney or Bladder Problems	
	Bowel Problems			Muscle Disorders	
	Cancer*			Nose Bleeds	
	Chickenpox			Orthopedic Disorders*	
	Congenital Defect*			Polio	
	Cleft Lip/Palate			Rheumatic Fever	
	Diabetes			Seizures	
	Ear Infections			Serious Accidents*	
	Frequent Sore Throats			Sickle Cell Disease	
	Hearing Problems			Surgery*	
	Head Injury			TB Contact	
	Heart Problems			Vision Loss	

***2.* Please answer the following questions:**

Yes ✓	No ✓	
		Has your child traveled outside of the United States within the last month?
		Has a family member traveled outside of the United States within the last month?
		Have you or anyone in your family cared for or been in contact with an ill person within the past month?
		Has your child or a family member suffered from an illness which caused them to develop fever within the last month?

3. **The child's health insurance status is as follows:**

_____ Health Insurance through parent job
_____ Medicaid
_____ CHIPS
_____ Other
____ None

Yes No 4. Is your child under medical treatment at this time?

If so, for what conditions? _____

5 List medications child is taking. _____

6. Name of doctor or clinic & Tel: _____

Further comments: _____

I authorize health related information to be released to appropriate staff for the care, safety, and welfare of my child.

Parent's signature: _____ Date: _____

This section to be completed by Campus Clinic Staff

Health Inventory Review by Campus Nurse completed on _____(date).

Temp_____ Pulse _____ Resp. _____ B/P _____

Campus Nurse Printed Name: _____ Signature _____

(Rev. 10/2014 yc/lgc)