

MSD of LAWRENCE TOWNSHIP

STUDENT HEALTH INVENTORY

Your child’s learning depends on maintaining good health. To assist in providing health services at school, please complete and return to the School Nurse.

Name: _____ Birth date: _____
Last First Middle

Grade: _____ School: _____ Male: _____ Female: _____

Parent/Guardian: _____ Phone: _____

Parent’s Employment _____
Father Phone Mother Phone

Cell Phone #'s: Father: _____ Mother: _____

E-mail Address: Father: _____ Mother: _____

Emergency Contacts: _____
(Other than parents) Name Phone Name Phone

Last school attended: _____
Name City State

Doctor’s Name _____ Hospital Preference _____

Dentist’s Name _____

Is the student under orthodontist’s care? Yes _____ No _____ Doctor’s Name _____

Please check if the student has any of the following conditions:

___ Allergies: Drug, food, other? Please list _____

What happens? _____

Is emergency medication used? Yes _____ No _____ Name of medication _____

___ Bee sting allergy: What happens? _____

Is an emergency medication prescribed for bee stings? Yes _____ No _____ Name of Medication _____

___ Asthma: Is an inhaler used? Yes _____ No _____ How often? _____ Date diagnosed: _____

List medications taken for asthma _____

Triggered by: _____

___ Diabetes: Takes insulin Yes _____ No _____ Blood sugar checked at school? Yes _____ No _____

___ Bone /Joint problems: Describe _____

Any physical restrictions: _____

___ Seizures: Describe _____

Date of last seizure: _____ Medications: _____

___ Heart condition: Describe _____

Any physical restrictions: _____

___ Sickle cell anemia: Recent hospitalizations for exacerbation? _____

Please check if your child has any of the following:

___ Vision Problem ___ Hearing Problems ___ Nosebleeds ___ Headaches

___ Glasses ___ Hearing Aid ___ Skin disorders ___ Migraines

___ Contacts ___ Frequent ear infections ___ Blood disorders ___ ADD/ADHD

List any other medical problems, surgeries, or other concerns that you would like the nurse to know. _____

What medications does your child take on a routine basis? _____

IF STUDENTS REQUIRE MEDICATIONS AT SCHOOL, PLEASE OBTAIN THE APPROPRIATE FORMS IN THE CLINIC. THIS MEDICAL INFORMATION MAY BE SHARED WITH APPROPRIATE STAFF ON A NEED-TO-KNOW BASIS TO ENSURE THE SAFETY OF YOUR CHILD.

Signature of legal parent / guardian _____ Date _____

