Student Health Inventory

Part One: Please provide the following information, although a physical exam is not required, we request that you also provide a copy of your child's most recent physical with his/her pediatrician. If an exam has not been completed within the last year, we recommend that this occur prior to the opening of school.

Student ______________________________ Grade ________

Date of Birth __________________________ Gender _______

List any previous illnesses, injuries or traumatic experiences that may have impacted your child's development.

Did any of these illnesses/experiences require hospitalization? If so, please describe the treatment and outcome.

List any allergies including food or seasonal allergies that your child may have. If any of these are serious and/or life-threatening, please advise us about the precautions that are recommended by your physician (including use of Epi-pen).

Is your child currently being treated for any conditions/health problems? If so, please provide details.

Has your child undergone a psycho-educational evaluation? Yes No

If so, please provide a copy of the report that you were issued – particularly the recommendations to the school. This information will be maintained in your child's file and can provide invaluable insights to optimize his/her experiences at Epiphany.

Physician's name ______________________________________ Practice _______________________________

Health Insurance Carrier __________________________________ Policy Holder's Name _____________________

Student Name:________________________________

Part Two: A copy of current shot records MUST be provided before the first day of school.

Parents complete the following:

Please circle any of the following illnesses and/or conditions that your child has or has had in the past:

Asthma	*Cystic Fibrosis*	*Hearing Probs.*
Bleeding Disorder	*Cerebral Palsy*	*Meningitis*
Bone/Muscle Probs.	*Dental Probs.*	*Mental Health Probs.*
Bowel Probs.	*Diabetes*	*Sickle Cell Anemia*
Cancer	*Ear Infections*	*Skin Disorders*
Convulsions/Seizures	*Heart Disorders*	*Stomach Problems*

List any allergies:

Does your son/daughter take any routine medications? Yes No
If so, please list and describe any salient side effects.

Does this medicine need to be administered at school? Yes No
If so, list the frequency and any special directions.

Part Three: This section should be completed by your **physician** if a physical exam occurs. In the event your child participates in interscholastic sports, you must have a sports physical completed.

Weight: ____________ **Height**: ___________

Vision:

Right	Left	Both
Far	*20/*	*20/*
Near	*20/*	*20/*

With correction? Yes No

Hearing: Pass Fail Pure Tone Level_________

500	1000	2000	3000
Right			
Left			

Hemoglobin/Hematocrit (if indicated): Normal Abnormal

TB Skin Test (if indicated): Normal Abnormal

Any other observations/recommendations that you would offer.

Signature of Physician/Provider: ____________________________________ Date: ________________