Student Health Inventory

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and returns this to the School Nurse. Name	Teacher			Grade_	Grade School					
Parent/Suardian				ealth. To assist in	providing hea	elth services at sch	ool, please complete	the follow	ving and	
Parent/Suardian	Name					Birthdate		Bov □	Girl □	
Parent's employment Father			First		Middle			-, <u> </u>	- _	
Father	Parent/	Guardian				Pho	ne #			
Father	Parent's	s employment								
Name				Phone		Mother	P	none		
Name	Fmerge	ncy Contacts								
Doctor's name						ame	Pł	none		
Doctor's name										
Date of last physical Date of last exam	Last Sch	iool attended				City	State			
Dentist's name	Name				•					
Doctor's name	Doctor's name					Date	e of last physical			
Allergies?	Dentist'	s name				Date of last exam				
Allergies?	Is stude	nt under an ortho	odontist's care? Ye	s 🗌 No 🗌	Doctor's nan	ne				
Allergies?	Does st	udent have:								
Has the allergy required emergency action in the past? Yes No Comments			Yes □ No □	To drug	s, food, insect	s, pollen? Please	list			
Bee sting allergy? Yes No Describe reaction Difficult breathing? Yes No Need emergency medication? Yes No Asthma? Yes No Triggered by Treatment Date Diabetes? Yes No Takes insulin? Yes No Date Diagnosed Describe seizure Medication Is student currently under a doctor's care for seizures? Yes No Describe Any physical restrictions? Medication? Yes No Describe Any physical restrictions? Describe Any physical restrictions? Difficulty seeing Ears: Frequent Infections Hearing Aid Distance Difficulty seeing Ears: Treatment Physical restrictions? Describe Any physical restrictions? Difficulty, explain Physical restrictions? Describe Distance Difficulty seeing Diadder Skin Distance Difficulty Distance Distance Difficulty Distance	_ _			Has the	Has the allergy required emergency action in the past? Yes ☐ No ☐					
Asthma? Yes No Triggered by Treatment Diagnosed by doctor Date Date Diabetes? Yes No Takes insulin? Yes No Date Diagnosed Date Date Diabetes? Yes No Describe seizure Medication Is student currently under a doctor's care for seizures? Yes No Heart condition? Yes No Describe Any physical restrictions? Medication? Yes No Bone or joint problems? Yes No Describe Any physical restrictions? Medication? Yes No Bone or joint problems? Yes No Describe Any physical restrictions? Medication? Yes No Check off the following regarding health concerns that pertain to student: Eyes: Glasses Contacts Difficulty seeing Ears: Frequent Infections Hearing Aid Hearing difficulty, explain Wear at School Other Distance Hearing difficulty, explain Wear at School Other Other: nosebleeds eating sleeping bladder skin phobias bedwetting ADD/ADHD Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Name of medication and reason for taking Sugeries (operations) Condition that prevents PE participation Sugeries (operations) Condition that prevents PE participation Sugeries (operations) Condition that prevents PE participation Sugeries Condition that prevents PE participation Suge	Bee sting allergy? Yes ☐ No ☐									
Diagnosed by doctor										
Diagnosed by doctor										
Diabetes?	Asthma? Yes ☐ No ☐									
Epilepsy/Seizures Yes No Describe seizure Medication Is student currently under a doctor's care for seizures? Yes No Heart condition? Yes No Describe Medication? Yes No Bone or joint problems? Yes No Describe Medication? Yes No Any physical restrictions? Medication? Yes No Any physical restrictions? Check off the following regarding health concerns that pertain to student: Eyes: Glasses Contacts Difficulty seeing Ears: Frequent Infections Hearing Aid Reading Crossed Lazy Eye Tubes Right Left Distance Hearing difficulty, explain Wear at School Other: nosebleeds eating sleeping bladder skin phobias bedwetting Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Name of medication and reason for taking List serious illness or injuries Surgeries (operations) Condition that prevents PE participation				Diagnos	sea by doctor		D	ate		
Date of last seizure			Yes ☐ No ☐	Takes insulin? Yes ☐ No ☐ Date Diagnosed						
Heart condition? Yes No Describe Any physical restrictions? Medication? Yes No Describe Any physical restrictions? Medication? Yes No Describe Any physical restrictions? Medication? Yes No Describe Any physical restrictions? Describe Any physical restrictions? Describe Any physical restrictions? Describe Any physical restrictions? Describe Des			Yes 🗌 No 🗌							
Heart condition? Yes No Describe Any physical restrictions? Medication? Yes No Describe Any physical restrictions? Check off the following regarding health concerns that pertain to student: Eyes: Glasses Contacts Difficulty seeing Ears: Frequent Infections Hearing Aid Reading Crossed Lazy Eye Tubes Right Left Hearing difficulty, explain Wear at School Other Other: nosebleeds eating sleeping bladder skin phobias bedwetting lungs neurologic headaches bowel dental ADD/ADHD Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Surgeries (operations) Condition that prevents PE participation										
Any physical restrictions?Medication? Yes No Bone or joint problems? Yes No Describe								Yes 🔲 N	0 🗆	
Bone or joint problems? Yes No Describe Any physical restrictions? Check off the following regarding health concerns that pertain to student: Eyes: Glasses Contacts Difficulty seeing Ears: Frequent Infections Hearing Aid Reading Crossed Lazy Eye Tubes Right Left Distance Hearing difficulty, explain Wear at School Other: nosebleeds eating sleeping bladder skin phobias bedwetting lungs neurologic headaches bowel dental ADD/ADHD Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Surgeries (operations) Condition that prevents PE participation	Heart condition? Yes ☐ No ☐		Describ	e		NA o di o oti o o o				
Any physical restrictions?							IVIEGICATION?	Yes ∐ I	ио 🗆	
Check off the following regarding health concerns that pertain to student: Eyes: Glasses	Bone or joint problems? Yes ☐ No ☐									
Eyes: Glasses				Any pny	ysicai restrictio	ons?				
Reading Crossed Lazy Eye Tubes Right Left Distance Black Bla	Check o	ff the following re	egarding health co	ncerns that pertai	in to student:					
Distance	Eyes:			=	ng Ear					
Other: nosebleeds eating sleeping bladder skin phobias bedwetting lungs neurologic headaches bowel dental ADD/ADHD Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Name of medication and reason for taking List serious illness or injuries Condition that prevents PE participation		_	☐ Crossed	☐ Lazy Eye				_		
Other: nosebleeds eating sleeping bladder skin phobias bedwetting lungs neurologic headaches bowel dental ADD/ADHD Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Name of medication and reason for taking List serious illness or injuries Condition that prevents PE participation		□ Distance				☐ Hearing diffi			nooi	
□ lungs □ neurologic □ headaches □ bowel □ dental □ ADD/ADHD Daily medication at home? Yes □ No □ At school? Yes □ No □ Emergency only? Yes □ No □ Name of medication and reason for taking List serious illness or injuries Surgeries (operations) Condition that prevents PE participation			_				_			
Daily medication at home? Yes No At school? Yes No Emergency only? Yes No Name of medication and reason for taking List serious illness or injuries Surgeries (operations) Condition that prevents PE participation	Other:		_				•	☐ bed\	wetting	
Name of medication and reason for taking		□ luligs	□ Heurologic	neadacties	□ powei					
List serious illness or injuriesCondition that prevents PE participation							only? Yes 🗌 No 🗌			
Surgeries (operations)Condition that prevents PE participation										
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Juier nearm miorillation of concerns							. pa: uupau0i i			

If student requires medication at school, or a change in PE participation, please obtain the appropriate form in the school office.

The Camden County School Nurse program for non-public schools is administered by the Southern NJ Perinatal Cooperative.