

Archie R-V School District STUDENT HEALTH INVENTORY

Your child's learning depends upon good health. To assist in providing health services at school please complete all questions and return to the school nurse.

Name _____ Grade _____
Address _____ City _____ Zip _____

Email address: _____

Parent/Guardian _____ Phone _____

Parent's Employment _____ Phone _____
_____ Phone _____

Emergency Contacts: Name _____ Phone _____
Name _____ Phone _____
Name _____ Phone _____

Doctor's Name _____ Phone _____

Has you child had a well-child or physical exam in the last 24 months? YES NO
Has you child had a dental exam in the last 12 months? YES NO

Circle the type of medical coverage your child has now:

Private insurance Medicaid/MC+/MoHealthNetforKids None

Where should your child be taken in case of emergency? _____

Should your child have a medical emergency, and we cannot reach you or your child's emergency contact, are we authorized to seek medical attention as necessary? Yes ___ No ___

DOES YOUR CHILD HAVE:

Allergies Yes* ___ No ___ To drugs, food, insects, bee stings, pollen? Please list _____
Has the allergy required emergency action in the past? Yes ___ No ___ Please explain _____

**If yes, please provide the school with Benedryl or an EpiPen for an emergency. A doctor's prescription and a written parental permission must accompany all medicines. It will also be necessary to fill out an Individual Health Care Action Plan to further complete your child's file.*

Asthma** Yes___ No___ If yes:
Yes___ No___ Does you child take daily asthma meds OR have
symptoms 2 or more times per week?
Inhaler? Yes___ No___

Note: If you marked that your child has asthma and uses an inhaler to treat his/her
asthma, we need to have an inhaler in the health room.

Diabetes** Yes___ No___ Takes insulin?_____ Date Diagnosed_____

Epilepsy/Seizures** Yes___ No___

Describe seizure_____

Date of last seizure_____

Medication(s)_____

Heart Condition** Yes___ No___

Describe specifically_____

Any physical restrictions?_____

Medications_____

Bone or Joint Problem** Yes___ No___ Scoliosis? Yes___ No___

Describe_____

Any physical restrictions_____

****If your child has Asthma, Diabetes, Seizures, Heart condition, Bone or Joint problems, please see the
school nurse so we may fill out an Asthma Action Plan or Individualized Health Care Action Plan to
further complete your child's file.**

Eyes: Glasses___ (reading___ distance___) contact lens___
crossed___ lazy eye___ difficulty seeing___

Ears: frequent infections___ tubes___ hearing difficulty___
Wears hearing aide: Right___ Left___ . Wears at school?___

Other Concerns:
nosebleeds___ eating___ sleeping___ bowel___ requires diapering___
skin___ bladder___ requires catheterization___ bed-wetting___ dental___
blood disorder___ neurologic___ lungs___ headaches___ blood pressure___
menstruation___ phobias(fears)___ ADD/ADHD___ pregnant___

Take daily medication at home? Yes___ No___ At school? Yes___ No___
Emergency only? Yes___ No___
Name of medication and reason for taking_____

List serious illness, injuries, and/or childhood diseases:

Other health information or concerns:

Parent/Guardian Signature: _____ Date: _____

