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.

OVER >

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: _____