



## HOUSTON INDEPENDENT SCHOOL DISTRICT

### HEALTH INVENTORY

SCHOOL \_\_\_\_\_

DATE \_\_\_\_\_

TEACHER \_\_\_\_\_

SCHOOL LAST ATTENDED \_\_\_\_\_

Please fill in this form and return to the teacher or nurse. The information given on this form will help the school staff to have a better understanding of your child's health needs:

Name \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_ Birth weight \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Have you ever been told by a doctor that your child had:**

	Age First Identified	Under Doctor's Care?		Age First Identified	Under Doctor's Care?
Asthma			Bone/Joint Problem		
Allergies			Rheumatic Fever		
Blood Disorder			Surgery/Fractures		
Diabetes			T. B. Disease		
Epilepsy/Seizures			Hearing Loss		
Heart Disease			Vision Loss		
Kidney Disorder			Severe Menstrual Cramps		
Cancer			Eating Disorder		

**Please check if you have observed any of the following in your child:**

Tires easily       Earaches       Wheezing, shortness of breath with exercise  
 Frequent headaches       Difficulty making friends       Nail Biting  
 Fainting       Coughs frequently at night       Restlessness

Has your child been seen by a doctor for any of the above?  Yes  No

Is your child on any kind of medication?  Yes  No

If so, what? \_\_\_\_\_

For what condition? \_\_\_\_\_

Further comment \_\_\_\_\_

What type of medical insurance do you carry for this child?

CHIP       Medicaid       HCHD       Private Insurance       None

Please see the School Nurse (or School Principal) if your child has other needs or is:

- A pregnant or parenting teen  
**and/or**
- Has a severe life-threatening food allergy

Signature \_\_\_\_\_