



HOUSTON INDEPENDENT SCHOOL DISTRICT

HEALTH INVENTORY

SCHOOL Sugar Grove Academy

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:
<ul style="list-style-type: none"> A pregnant or parenting teen and/or Has a severe life-threatening food allergy

Signature _____