



# HOUSTON INDEPENDENT SCHOOL DISTRICT

## HEALTH INVENTORY

SCHOOL DeBakey High School. DATE \_\_\_\_\_ Grade \_\_\_\_\_

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 \_\_\_\_\_

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

Does your child have any Pre-Existing Medical or Emotional conditions?

Specify please \_\_\_\_\_ Please provide Doctor's statement \_\_\_\_\_

Please see School Nurse, School counselor or Principal if your child has **other needs, life-threatening food allergy, is pregnant or had any hospitalization.**

Signature \_\_\_\_\_

**Must see the School Nurse if your child is using an Inhaler or has an Epipen Or taking any medication during school hours.**