HOUSTON INDEPENDENT SCHOOL DISTRICT
School Health Department

# HEALTH INVENTORY

SCHOOL_____ DATE_____

TEACHER_____
Please fill in this form and return it to the teacher or nurse at the earliest possible date. The information given on this form will enable the school staff to have a better understanding of the pupil's health status.

Name_____ Sex_____ Birthdate_____ Birth weight_____

Address_____ Phone_____

| Disease History | Age | Disease History | Age |
|---|---|---|---|
| Asthma | | Orthopedic | |
| Allergy (specify) | | Poliomyelitis | |
| Blood Disorder | | Rheumatic Fever | |
| Convulsions | | Serious Accident | |
| Diabetes | | Surgery/Fractures | |
| Epilepsy | | T.B. Contact | |
| Heart Disease | | Hearing Loss | |
| Kidney Disorder | | Vision Loss | |

If this pupil has had any of the above conditions, did he/she receive medical care?
Yes_____ No_____

Is he/she under treatment now? Yes_____ No_____

Please check any of the following signs and symptoms you have recently observed.

_____Tires easily
_____Underweight
_____Overweight
_____Frequent headaches
_____Frequent colds
_____Frequent sore throats
_____Frequent nose bleeds
_____Earaches
_____Fainting
_____Frequent stomach-aches
_____Nail Biting
_____Restlessness
_____Shyness
_____Does not like school
_____Does not get along with others

Has the pupil consulted a physician about the above symptoms? Yes_____ No_____
Has the pupil had a complete physical in the past year? Yes_____ No_____
Is this pupil on any kind of medication?_____

If so, what?_____

For what condition?_____

Is this pupil under medical care at this time?_____

Name of doctor or clinic_____

Further comment_____

Has the pupil ever attended the Houston Public Schools?_____
Name of school – date attended

PLEASE FEEL FREE TO CONSULT WITH THE SCHOOL STAFF ABOUT HEALTH PROBLEMS

Signature_____

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