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		Yes	Bone/Joint Problem		Yes
Allergies		Yes	Rheumatic Fever		Yes
Blood Disorder		Yes	Surgery/Fractures		Yes
Diabetes		Yes	T. B. Disease		Yes
Epilepsy/Seizures		Yes	Hearing Loss		Yes
Heart Disease		Yes	Vision Loss		Yes
Kidney Disorder		Yes	Severe Menstrual Cramps		Yes
Cancer		Yes	Eating Disorder		Yes

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 _____