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 ______________________________