

PARKLAND SCHOOL DISTRICT
HEALTH INVENTORY

Name of Child: _____

Date: _____

Please circle Yes or No, if "Yes" explain and give date(s); use back of page if needed.

1. Allergic to Medication(s): **YES/NO** _____
2. Allergic to Food(s): **YES/NO** _____
3. List any other allergies: _____
4. Food or dietary restrictions: **YES/NO** _____
5. Asthma: **YES/NO** _____
6. History of hospitalization **YES/NO**: _____
7. Ever had surgery: **YES/NO** _____
8. Fractured bones: **YES/NO** _____
9. Concussion(s) / Severe head injury: **YES/NO** _____
10. Convulsions: **YES/NO** _____
11. Seizure Disorder: **YES/NO** _____
12. Speech problems: **YES/NO** _____
13. Frequent earaches and/or ear infections: **YES/NO** _____ Hearing loss and/or ear surgery: **YES/NO** _____
14. Vision problems: **YES/NO** _____ Wears glasses/contact lenses: **YES/NO** Eye surgery: **YES/NO** _____
15. Chicken pox disease: **YES/NO** Date: _____
16. Eczema or other skin diseases: **YES/NO** _____
17. Heart problems or congenital heart disease: **YES/NO** _____
18. Open heart surgery: **YES/NO** _____
19. Diabetes: **YES/NO** _____
20. Urinary/bladder problems: **YES/NO** _____
21. Intestinal/bowel problems: **YES/NO** _____
22. Any physical, developmental, or health problems at birth: **YES/NO** _____
23. Medication: **YES/NO** Please list all current medication(s): _____
24. Any medication(s) to be kept at school: **YES/NO** _____
25. Any physical restrictions: **YES/NO** _____
26. Attention-Deficit/Hyperactivity Disorder: **YES/NO** _____
27. Psychological/Emotional Problem: **YES/NO** _____
28. Any other health problems/diseases/issues: **YES/NO** _____

This health inventory data will be part of your child's health record and will be shared with his/her teacher and essential personnel.

Signature of parent/guardian

Date