

STUDENT HEALTH INVENTORY

(This form is to be used for all new enrolling students and all Special Education Eligibility Staffings)

This form is confidential and will only be shared with Adams 12 Five Star School's staff on a need to know basis for the safety and/or educational progress of your student. **Please complete front and back.**

*** It is the responsibility of the Parent/Guardian to contact the Transportation Department at (720) 972-4299 to inform them of any health conditions if your student rides the bus.*

STUDENT NAME: _____		School: _____	
Grade: _____	Birthday __/__/__	Age _____	<input type="checkbox"/> M / <input type="checkbox"/> F Lives with: _____
Parent(s)/Guardian(s) Names: _____			
Medical Insurance: (Circle) Private Insurance CCHP Medicaid ID# _____ None			
Medical Diagnosis/Conditions: _____			
Diagnosed by Physician: (Name/Date) _____			
Person completing form: _____			
	Name	Signature	Date
Relationship to child: _____		Home phone: _____	
		Work phone: _____	
E-mail address: _____			

MEDICAL HISTORY

ADD <input type="checkbox"/> Yes <input type="checkbox"/> No ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No Autism <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Condition(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Limitations: _____
Allergies/Reactions <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, to what? _____ Type of Reaction: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	Immune System Disorder (Lupus, Transplants) <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Date: _____
Asthma / Respiratory Conditions (pneumonia, bronchitis) <input type="checkbox"/> Yes <input type="checkbox"/> No Types/Dates _____	Kidney Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Bone Disease / Deformity <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____ Special Equipment: _____	Mental Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Cancer / Blood Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Date: _____	Neuro/Muscular Condition <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Communicable Diseases (measles, TB, hepatitis) <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Date _____	Skin Condition <input type="checkbox"/> Yes <input type="checkbox"/> No Serious Burns <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Diabetes Type _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Glucose monitoring @ school <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin required while @ school <input type="checkbox"/> Yes <input type="checkbox"/> No Snacks/diet monitoring @ school <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Bowel Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Ear Infections <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery (tubes placed) <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: _____	Surgeries/Hospitalizations <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Reason _____ Date _____ Reason _____ Date _____ Reason _____
Enuresis (bedwetting) <input type="checkbox"/> Yes <input type="checkbox"/> No Encopresis (soiling) <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency/Age: _____	Syndromes <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____ Limitations: <input type="checkbox"/> Yes <input type="checkbox"/> No Describe: _____
Epilepsy/Seizure Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Frequency: _____ Limitation: _____ Date of last seizure: _____	Traumatic Brain Injury <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Cause: _____ Extent / Outcome: _____

MEDICATION(S)

Please list medications taken at home and school. If additional space required, please attach separate list.

Drug Name	Dosage	Time(s)	Reason

**** Please Note: The Adams 12 School District requires both a written physician's order and written parent permission in order to administer medication and/or procedures at school for your child.**

WELL CHILD CARE

Date of Last Physical Exam: _____ Physician's Name: _____
 Date of Last Vision Exam: _____ Requires glasses/contacts: Yes No Concerns: _____
 Date of Last Hearing Exam: _____ Hearing Loss? Yes No Hearing Aid? Yes No
 Date of Last Dental Exam: _____
 Any other vision/hearing/dental concerns: _____

LIFESTYLE

Nutrition Appetite: Good Fair Poor Concerns: _____
Fitness Activity level: Very active Active Quiet
 Describe types of exercise: _____
(i.e. organized sports, riding bikes, running, plays outside, etc.....)
Sleep Bedtime @ _____ Wakes up @ _____ Concerns: _____

MEDICAL CARE REQUIRED AT SCHOOL

Please circle all that apply: GT feeding, nebulizer treatments, catheterization, oxygen, assisted oral feedings, toileting and diapering. Other (please list): _____

Pre-K through Grade 5 (Optional)

BIRTH HISTORY

Early history not known

Prenatal care: Yes No
 Pregnancy was: Normal Complicated, _____
Explain any conditions (i.e. toxemia, infection, pre-mature labor, smoking, drugs, etc.....)
 Length of pregnancy: _____ Type of Delivery: (Circle) Vaginal C-Section Forceps/Suction
 Labor/Delivery was: Normal Complicated, _____
Explain (i.e. required oxygen, breech, chord around neck, bleeding etc.....)
 Birth weight: _____ Describe any newborn complications: _____
Explain (i.e. jaundice, required oxygen, intensive care, etc...)
 Length of hospital stay: Mother _____ Infant _____

DEVELOPMENTAL HISTORY

Early history not known

Age: Crawled @ _____ Walked @ _____ First words @ _____ Weaned to cup @ _____
 Fed self finger foods @ _____ Toilet trained @: Bowel _____ Bladder _____
 Were there any early childhood concerns about your child: _____
(i.e. speech, language, motor, developmental etc.....)

Any additional concerns: _____

