HOUSTON INDEPENDENT SCHOOL DISTRICT

HEALTH INVENTORY

SCHOOL _____ DATE _____

HISD ID# _____ 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 __/__/__ Parent/Guardian Name _____

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 Yes ☐ No ☐

and/or

- Has a severe life-threatening food allergy Yes ☐ Explain _____ No ☐

Signature _____