Norwood Public School Health Services

HEALTH INVENTORY

Parents: ***Please fill out this form for each child, indicating any of the following. If no special medical condition exists, write N/A in each area. If any condition should develop while your child is a registered student at our school please notify the school nurse.***

Student's name _____ Birthdate_____ Grade____

1. Indicate any special medical, physical, or emotional condition that would be wise or essential for the school nurse, and the office personnel or teachers to know.

   _____

   _____

   Please detail any considerations regarding this condition, including prescribed medications and instructions for staff. Please indicate any medications (especially prescription medication) taken at home.

   _____

   _____

2. Identify any allergies your child has. These could include bee or other insect stings, foods, medications, chemicals, or seasonal allergies to mold or hay fever.

   _____

3. What symptoms does your child have when having any allergic reaction? These could include rashes, swelling, headaches, congestion, shortness of breath or any others. Please be specific. (For insect and food allergies you will be asked to complete a more detailed allergy assessment and action plan).

   _____

   _____

4. Does your child have medical problems requiring long-term treatment, such as pneumonia, ear infections, tonsillitis, ADHD? If Yes, please list condition(s).

   _____

   _____

5. Does your child have asthma? _____ If your child has asthma, please list any medication he/she takes on a daily or as needed basis. (You will be asked to complete a more detailed asthma assessment and action plan.)

   _____

   _____

6. Has your child had a serious illness requiring the following?

   Hospitalization _____

   Surgery _____

Please be sure to complete the information on the back of this page

7. Please list any medication your child takes on a daily or as-needed basis.

_____

8. Please list any medications your child has taken for more than two weeks.

_____

9. Has your child had any special tests such as X-rays, EEG, blood tests, etc.?

_____

10. Has your child had any serious accidents or injuries? _____

_____

11. Has your child had emotional/behavior problems? _____

_____

12. Has your child had a serious illness that did not require hospitalization?

_____

13. Has your child had an extreme weight change, either gaining or losing weight?

_____

14. Has your child had any special examinations, such as vision, hearing, neurological, psychological, etc.? _____

_____

15. Glasses _____ Known vision _____

16. Ear infections _____ tubes inserted? _____ Hearing aid? _____

17. Has your child ever had a seizure? _____ Type of seizure? _____
On seizure medication? _____ Date of last seizure _____ (If yes to these questions you will be asked to complete a more detailed assessment and action plan.)

18. Menstrual cycle _____ Duration _____ Difficulties _____
Medication for menstrual problems _____

While my child is a student registered at the Norwood Public School I consent to the school nurse sharing any health information pertinent to my child's school progress with other school personnel and/or other health care providers to which my child may be referred.

_____ _____

Signature of Parent or Guardian Date

PLEASE RETURN TO THE SCHOOL NURSE.