***(School Name Here)***

**Student Health Inventory**

**Name:**   **Grade:**

**Address:** **Birthdate:**

|  |  |
| --- | --- |
| **Contact:** | **Contact:** |
| (Mother)  H)  W)  C)  Email: | (Father)  H)  W)  C)  Email: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician:** |  | **Health Insurance:** |  |
| **Dentist:** |  | **Dental Insurance:** |  |
| **Vision:** |  | **Vision Insurance:** |  |

|  |  |  |
| --- | --- | --- |
| **ADD/ADHD** | NO |  |
| **Allergies** | NO |  |
| **Asthma** | NO |  |
| **Diabetes** | NO |  |
| **Epilepsy/Seizure** | NO |  |
| **Heart Condition** | NO |  |
| **Bone or Joint Problem** | NO |  |
| **Stomach, Bowel, or Bladder** |  |  |
| **Other:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Wears Glasses: Yes No** | **Hearing Aides: L R No** | **Tubes in Ears: L R No** | **Special Diet: Yes No** |

|  |
| --- |
| **Current Medication:** |
|  |

**ALL students must have written record of all required immunizations on file at school before they can attend on the first day.**

**Medical Emergencies**

In the event of an anaphylactic emergency, I authorize trained school personnel to administer pre-filled epinephrine (Epi-Pen) and/or Benadryl. I also authorize trained school personnel to administer first-aid to my child.

In the event that my child is injured or becomes ill and/or needs medical attention for any reason, and I cannot be contacted, this authorization will serve as my request and authority for school authorities to call an ambulance service for the purpose of conveying my child to the hospital or physician, and I authorize any and all medical treatment provided to my child. I hereby authorize the school to provide to the attending physician, hospital or clinic relevant data judged necessary for treatment from my child’s file. I fully understand that I shall be responsible for all costs of ambulance service and any medical care or treatment provided to my child. I also give permission for the sharing of health information with appropriate staff members and medical personnel when necessary for my child’s health and safety.

If your child will require ANY medication to be administered at school, please notify the school for the appropriate paperwork to fill out which will need to be signed by the parent/legal guardian before medication will be given. The medication has to be in the original bottle. The script on the bottle will serve as the physician order.

**I give permission for my child to participate in the School Health Programs and verify the above information to be accurate. I also give permission for the Macon County Health Department and the school to exchange information regarding my child’s immunization record**

**Signature of Parent/Legal Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**