Highlands School District
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Health Inventory for Elementary Students

Name _____ **Sex** _____
Last First Middle

Address _____ **Grade** _____

Phone No. _____ **Birthdate** _____ **Birth Certificate No.** _____
(if applicable)

Father's Name _____
Last First MI

Mother's Name _____
Last First Maiden

Name of Guardian if other than Parent _____

What is your relationship? _____

I. IMMUNIZATION HISTORY (Give month - day - year)

VACCINE	DOSES				
Diphtheria and Tetanus	1	2	3	4	5
Polio	1	2	3	4	
Measles ("Hard") ("Red")	1	2			
Rubella	1	2			
Mumps	1	2			
Varicella (Chicken Pox)	1	2	OR DATE OF DISEASE:		
Hepatitis B	1	2	3		

HiB _____ _____ _____ _____

Date of last Tuberculin Test _____

Did your child have a reaction to the test? **Yes** _____ **No** _____

Sickle Cell Test _____
Month and Year

II. HISTORY OF ILLNESS (Give age)

Allergy - To what: _____

_____ Anemia	_____ Diabetes	_____ Heart Disease	_____ Rheumatic Fever
_____ Asthma	_____ German Measles	_____ Hernia (Rupture)	_____ Skin Problems
_____ Chicken Pox	_____ Hay Fever	_____ Measles	_____ Tuberculosis
_____ Convulsions/ Seizures	_____ Hearing Problem	_____ Mumps	_____ Vision Problem

Comments: _____

Surgery _____ **Injury** _____

Any other serious illness? _____

III. HISTORY OF SYMPTOMS (Give age)

_____ Frequent Colds	_____ Frequent use of toilet	_____ Worries a great deal
_____ Sore throats	_____ Frequent stomach ache	_____ Many fears
_____ Nosebleeds	_____ Toothache	_____ Nervousness
_____ Persistent cough	_____ Frequent pains in legs	_____ Tires easily
_____ Frequent headaches	_____ Bedwetting	_____ Weight problems
_____ Frequent Ear Infections	_____ Angers easily	_____ Speech/Language Problems

Has your child ever received speech therapy? Yes _____ No _____

Has your child ever received physical therapy? Yes _____ No _____

Has your child ever received occupational therapy? Yes _____ No _____

IV. MEDICAL CARE

Name of child's doctor or clinic _____

Date of most recent visit _____ **Reason** _____

Is your child on medication? Yes _____ **No** _____ **What medicines?** _____

V. DENTAL CARE

Name of child's dentist or dental clinic _____

Date of last visit _____

Was all necessary dental work completed? Yes _____ **No** _____

VI. OTHER HEALTH PROBLEMS

Are there any other health problems or family matters which you think would be helpful for the school to know? _____

_____

_____

VII. INSURANCE COVERAGE

What is your child's source of medical insurance? _____

_____
Parent or Guardian's Signature

If both parents work, please list a business phone number _____

Home phone number _____