Loomis Union School District
Annual Student Health Inventory

Print

Returning Students fill out the form in full. Check "Yes", if new condition has occurred in the last year ☐**YES** ☐**NO**

New Students fill out the form in full. Initial any medical condition that pertains to the above named student. Attach a supplemental sheet to this form if you would like to provide more detailed information.

Initial	Condition description	Health code
_____	Asthma, reactive airway disease, exercise-induced asthma that requires **daily medication and/or an inhaler. Please specify (including) asthma triggers**_____	AS
_____	Diabetes, Type 1 or 11; wears insulin pump, uses glucometer **Please specify** _____	DM
_____	History of seizures, epilepsy, convulsions or treated with medication **Please specify date of last seizure**_____	S
_____	Significant allergic reaction (bees, peanuts, latex, etc.). **If uses Epi-pen, MD form req'd** **Please specify**_____	AL
_____	Learning disability (ADD, ADHD, dyslexia, etc.) that requires medication **Please specify** _____	LD
_____	Migraines or significant headaches that impact school performance **Please specify** _____	HA
_____	Medication request for school, including prescription or over-the-counter. **MD Form Req'd**	SM
_____	Orthopedic problems (scoliosis, arthritis, joint problems, cast/traction, etc.) **Please specify** _____	OR
_____	Heart condition (murmurs, pacemaker, valve disease, surgical history, etc.) **Please specify**_____	CV
_____	Significant recent illness/injury/surgery within the last 12 months (car accident, broken bone, Mononucleosis, Lyme disease, Whopping cough, Chicken pox, etc.) **Please specify** _____	HHx
_____	Medications taken at home on a daily basis, including vitamins and herbal supplements **Please specify** _____	HM
_____	Sensory deficit (hearing or visually impaired, hearing aids, glasses, contact lenses, etc.) **Please specify** _____	SEN
_____	Hepatitis A, B, or C, positive TB test, HIV, Meningitis or infectious disease **Please specify** _____	INF
	Depression, anxiety/panic disorder, schizophrenia, previous suicide attempts and/or on daily Mental health medications or treatment **Please specify** _____	MH

My signature indicates that I understand the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

Parent Signature_____Date_____