Academy Health Inventory

Information provided through this form will be used to assess any health needs your child may have during the school day. School staff my contact parent(s)/guardian(s) for further clarification or relevant health information. Please notify school when there are significant changes to your child's health or medical needs.

Child Name:_____ Date of Birth:_____ Age:_____ Gender: ☐M ☐F
Grade:_____ Previous School/District Attended:_____
Medical Insurance: ☐ Private Insurance ☐ CHP+ ☐ Medicaid ☐ Uninsured
Form completed by:_____
Name (Print) Relationship to child Date
Home Phone:_____ Work Phone:_____ Cell:_____

MEDICAL DIAGNOSES:

Check ALL that apply:	***Diagnosed by:***	***Diagnosis date:***
AD/HD ***Type:_____***	Provider:	Date:
Allergies: ***Type: Mild Moderate Severe*** ***If yes, to what:_____***	Provider:	Date:
Asthma/Respiratory	Provider:	Date:
Autism	Provider:	Date:
Communicable Disease: ***If yes, please list***	Provider:	Date:
Diabetes ☐ ***Type I*** ☐ ***Type II***	Provider:	Date:
Enuresis (Bedwetting)/Urinary Disorder	Provider:	Date:
Epilepsy/Seizure Disorder	Provider:	Date:
Headaches/Migraines	Provider:	Date:
Hearing Loss/Ear Infections	Provider:	Date:
Heart Condition	Provider:	Date:
Immune System Disorder	Provider:	Date:
Mental Disorder	Provider:	Date:
Neuro/Muscular Disorder	Provider:	Date:
Skin Conditions	Provider:	Date:
Stomach/Bowel Disorder/Encopresis (Soiling)	Provider:	Date:
Syndromes: ***If yes, please list on***	Provider:	Date:
Traumatic Brain Injury	Provider:	Date:
Hospitalizations/Surgeries: ***If yes, please list***	Provider:	Date:
Other		

☐ **Healthy Child- No concerns**

MEDICATION(S)

Please list medications taken at home and school. If additional space required, please attach separate list.

The Academy requires both a written physician's order and written parent permission in order to administer medication and/or procedures at school for your child.

****Any student medications not being provided to the school will require a medication opt-out form. This includes inhaler, epi-pen, etc).****

Drug Name	Dosage	Time(s)	Reason

MEDICAL CARE REQUIRED AT SCHOOL

Please circle all that apply: GT feeding, nebulizer treatments, catheterization, oxygen, assisted oral feedings, toilet and diapering. Other (please list):_____

WELL CHILD CARE

Date of Last Physical Exam:_____ Physician's Name:_____

Date of Last Vision Exam:_____ Requires glasses/contacts: □Yes □No Concerns:_____

Date of Last Hearing Exam:_____ Hearing Loss? □Yes □No Hearing Aid? □Yes □No

Date of Last Dental Exam:_____

Any other vision/hearing/dental concerns:_____

LIFESTYLE

Nutrition Appetite: □Good □Fair □Poor Concerns:_____

Fitness Activity Level: □Very Active □Active □Quiet

Describe types of exercise:_____

(i.e. organized sports, riding bikes, running, playing outside, etc.)

Sleep Bedtime @ _____ Wakes up @ _____ Concerns:_____

Pre-K through Grade 5 (Optional)

BIRTH HISTORY **Early history not known □**

Prenatal Care: □Yes □No

Pregnancy was: □Normal □Complicated,_____

Explain any conditions (i.e. toxemia, infection, pre-mature labor, smoking, drugs, etc.)

Length of pregnancy:_____ Type of Delivery: (*Circle*) Vaginal C-Section Forceps/Suction

Labor/Delivery was: □Normal □Complicated,_____

Explain (i.e. required oxygen, breech, chord around neck, bleeding, etc.)

Birth weight:_____ Describe any newborn complications:_____

Explain (i.e. jaundice, required oxygen, intensive care, etc.)

Length of hospital stay: Mother_____ Infant_____

DEVELOPMENTAL HSITORY **Early history not known □**

Age: Crawled @ _____ Walked @ _____ First words @ _____ Weaned to cup @ _____

Fed self finger foods @ _____ Toilet trained @: Bowel_____ Bladder_____

Was there any early childhood concerns about your child:_____

(i.e. speech, language, motor, developmental, etc.)

Any additional concerns:_____

Parent Signature:_____ **Date:**_____