FORT ZUMWALT SCHOOL DISTRICT
STUDENT HEALTH INVENTORY

Student: _____
Last First M.I.

School: _____ Grade: _____ Date of Birth: _____

Sex: ☐ M ☐ F

Check all that apply to your child:
(use back if necessary)

		(Yes)	(No)
☐ ADD / ADHD	Medication?	☐	☐
☐ Allergies, seasonal	Medication?	☐	☐
☐ Allergies, food	Epi Pen?	☐	☐
☐ Allergies, insects	Epi Pen?	☐	☐
☐ Allergies, medication			
☐ Allergies, other			
☐ Asthma:	Medication?	☐	☐
☐ mild ☐ moderate ☐ severe			
☐ Diabetes			
☐ difficulty hearing			
☐ tubes			
☐ hearing aids			
☐ hearing loss			
☐ difficulty seeing			
☐ glasses			
☐ contacts			
☐ epilepsy / seizures			
☐ heart condition / disease			
☐ mental / emotional condition			
☐ migraines	Medication?	☐	☐
☐ nosebleeds: (mild - moderate - severe)			
☐ orthopedic problems			
☐ skin condition			
☐ wheelchair / braces / walker			
☐ other:			

**District policy requires a doctor's signed, written request for administration of prescription medication.*

MEDICATIONS: * list dosages and times:

taken at home
1. _____
2. _____
3. _____

taken at school
1. _____
2. _____
3. _____

(use back if necessary)

Serious Illness, Injuries or Hospitalizations
list date and explanation:

/ /
/ /
/ /

(use back if necessary)

Does your child need:

☐ special seating
☐ restricted physical education (need Dr. note)

Other conditions the school should be aware of:

1.
2.
3.
4.

(use back if necessary)

Local Physician's name & telephone number

Name Address Telephone

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me I hereby authorize the school to take the steps necessary to insure the well being of the above-named child, which may include calling 911. If the parent(s)/guardian(s) cannot be reached, the emergency contacts provided will be called. The cost of medical attention and ambulance is the responsibility of the parent(s)/guardian(s). This information is confidential and will be shared with school personnel when deemed necessary.

NOTE: Please keep the office informed of current emergency contact information.

Signature of Parent / Guardian *(REQUIRED)* Relationship Date

You will be requested to complete and update the Student Health Information form annually.