

HEALTH INVENTORY FORM

Please fill in this health inventory form. This information is used to contact you if your child becomes ill or injured during school hours. It is to be part of your child's permanent record. All information is confidential and will only be shared with faculty as is absolutely necessary.

School Health Nursing Staff
Chariton County Health Center

Grade _____

Student's Name _____ Sex _____ Birthdate _____
Last First MI

Address _____ Home Phone _____
Street/PO Box City Zip

Parent/Guardian Name _____ Parent/Guardian Name _____

Parent/Guradian Contact Number: _____ Parent/Guardian Contact Number: _____

Employer(s) _____ Phone(s) _____

This is needed for the School Health Grant statistics—Please complete thoroughly—Thank You!

Physician's Name _____ Physical Exam in past 12 Months? Yes No Month ___ Year ___

Dentist's Name _____ Dental Exam in past 12 Months? Yes No Month ___ Year ___

Does your child have health insurance? Yes No Medicaid/MC+? Yes No

(Please indicate your child's health insurance. If your child has no health insurance or is left blank, you will receive information on MC+ For Kids.)

Neighbor or Relative to be called in case parents/guardians cannot be reached:

Name _____ Phone _____

Name _____ Phone _____

Does your child have any allergies to medicine or foods? Yes No If YES, to what and describe reaction _____

Does your child have any health problems or medication that the nurse/teacher should be aware of? Yes No

If the answer is "YES", please specify. (use back of sheet if needed) _____

Please list type and date of any immunizations(vaccines or shots)/surgeries/hospitalizations since school dismissal in May _____

NOTE: NO MEDICATION OF ANY KIND CAN BE GIVEN AT SCHOOL UNLESS SUPPLIED BY PARENT AND ACCOMPANIED BY WRITTEN PERMISSION AND INSTRUCTION.

Parent/Guardian Signature

Date

***PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE WITH YOUR CHILD BEFORE AUGUST 30, 2008**