

Student Name: _____
Grade: _____
School: _____

Sweetwater County School District Number One
P.O. Box 1089
Rock Springs, Wyoming 82902-1089

STUDENT HEALTH INVENTORY

HEALTH PROBLEMS AND HISTORY

(Please check box as appropriate)

- NO KNOWN PROBLEMS
- Asthma: Limitations No Limitations
- ADD/ADHD
- Allergies: Medication _____
Food _____
- Autism / Autism Spectrum
- Bedwetting
- Birth Defects
- Bladder Problems
- Blindness
- Blood Disorder
- Bone Problems
- Bowel Problems
- Chicken Pox Date: _____
- Diabetes
- Eczema / Skin Problems: _____
- Epilepsy
- Eye Problems: Glasses Contacts
Last Eye Exam: _____
- Fainting Spells
- Headaches
- Hearing Impairment: Tubes
- Hearing Aid FM System
- Heart Problem
- Multiple Disabilities
- Neuro-Muscular Disease
- Seizures: Type _____
- Speech - Language Problems
- Physical Activity Limits / P.E. Restrictions
- Other _____

STUDENT TAKING MEDICATIONS:

YES NO

MEDICATION NAME: _____

NEED TO TAKE AT SCHOOL:

YES NO

IF YES: Authorization for Administration of
Medication form required.

PHYSICIAN Name: _____

PHONE: _____

DENTIST: _____

School nurse may contact listed physicians for questions/concerns

Health Insurance _____

REQUESTED ACCOMMODATIONS FOR STUDENTS HEALTH PROBLEMS

NO Accommodations needed.

Accommodations needed:

Parent Signature for Accommodations

**By signing below, I authorize Sweetwater
County School District Number One, State of
Wyoming, to release the information
specified to Transportation Staff and School
Staff directly involved with my child.**

Parent/Guardian Signature

Date

(FOR NURSES USE ONLY)

REFERRAL: _____

School Nurse Signature