MOUNT PLEASANT CENTRAL SCHOOLS
STUDENT HEALTH INVENTORY

Your child's learning depends upon good health. To assist in allowing us to provide a safe environment for your child please fill out the following questionnaire and return to the school nurse.

Student's name_____ Birth date_____ Boy___ Girl___

Teacher_____ Grade_____

Does your child have:

Allergies? Yes___ No___ To drugs, food, insects, pollen
Please list_____
Bee sting allergy? Yes___ No___
Describe reaction
Difficulty breathing? Yes__No__
Has the allergy required emergency action? Yes__ No__
Describe treatment_____

Asthma? Yes____ No Triggers_____
Treatment_____

Diabetes? Yes____ No Takes insulin? Yes__No__
Date diagnosed_____

Epilepsy/Seizures? Yes___ No___ Describe seizure_____
Date of last seizure_____
Medication_____

Heart condition? Yes___ No___ Describe_____
Any physical restrictions? Yes__ No__
Describe restrictions_____

Bone or joint problem? Yes___ No___ Describe_____
Describe physical restrictions_____

Check off the following regarding health concerns that pertain to your child:

Eyes: wears glasses___ distance__ reading__ contacts__
Other vision problems_____

Ears: frequent infections__ tubes___ hearing difficulty___
Hearing aide: right__ left___

Other: nosebleeds___ eating__ sleeping__ bladder__ menstruation__ lungs__neurologic__
Headaches__ bowel__ blood disorder__ phobias__ ADD/ADHD__ dental__ bedwetting__
Skin__ blood pressure__ Other ___
Comments_____

Daily medication? Yes___ No___ At School? Yes___ No___
Name of medication and reason for taking_____
List any serious injuries or illnesses_____
Surgeries_____
Conditions that require physical education modifications_____
Type of modification_____

PLEASE CHECK ONE OF THE FOLLOWING

_____ You may share the information on this form with teachers and personnel who are responsible for my child during the school day.

_____ I wish this information to remain confidential in the health office.

_____ _____
Signature of parent/guardian Date