Orange Unified School District
Student Health Inventory

Date _____ **Grade** _____ **Birthdate** _____

Student Name _____ **Male** ☐ **Female** ☐
Last *First* *Middle*

School Last Attended _____ **City** _____ **State** _____

HEALTH STATUS	NO	YES	DESCRIBE IF YES	NO	YES
ALLERGIES	☐	☐	Allergic to:		
ASTHMA	☐	☐	• Mild ☐ Severe ☐ • Specify type and/or cause of asthma attack: _____ • Takes daily medication: o If yes, specify: • Takes emergency medication: o If yes, specify:	 ☐ ☐	 ☐ ☐
BEE STING ALLERGY	☐	☐	• Needs antihistamine tablet if stung • Needs adrenalin injection if stung	☐ ☐	☐ ☐
DENTAL PROBLEM	☐	☐	• Has received dental care • Date of last dental exam: _____	☐	☐
DIABETES	☐	☐	• Tests blood routinely • Has glucagon injection	☐ ☐	☐ ☐
EAR INFECTIONS	☐	☐	• Occasionally ☐ Frequently ☐ • Under doctor's care: • Date of last doctor's visit: _____	☐	☐
EPILEPSY OR SEIZURES	☐	☐	• Takes daily medication • If yes, specify: _____	☐	☐
HEART CONDITION	☐	☐	• Under doctors care • Specify restrictions at school: _____	☐	☐
ORTHOPEDIC PROBLEM	☐	☐	• Under doctors care • Specify any restrictions at school: _____	☐	☐
SERIOUS INJURY NOW OR IN PAST	☐	☐	• Specify:		
OTHER ILLNESS NOW OR IN PAST	☐	☐	• Specify: • Takes daily medication o If yes, specify: • Takes emergency medication o If yes, specify:	 ☐ ☐	 ☐ ☐
SURGERY/OPERATIONS	☐	☐	• Specify:		
HAS HEALTH CONDITION WHICH PREVENTS PARTICIPATION IN REGULAR P.E.	☐	☐	• Specify condition and limitations:		
HAS TROUBLE SEEING AT A DISTANCE	☐	☐	• Wears glasses • Wears contact lenses • Date of last visit with eye doctor _____	☐ ☐	☐ ☐
HAS TROUBLE SEEING CLOSE UP	☐	☐	• Wears glasses • Wears contact lenses • Date of last visit with eye doctor _____	☐ ☐	☐ ☐
HAS TROUBLE HEARING	☐	☐	• Wears hearing aids • Specify any needs at school:	☐	☐
OTHER HEALTH PROBLEM	☐	☐	• Specify problem and any medications:		