



Turlock Unified School District

# 2022-23 Annual Health Inventory

**THIS IS A REQUIRED FORM TO BE COMPLETED EVERY SCHOOL YEAR. IT IS DUE THE FIRST DAY OF SCHOOL.**

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

Is your child under the care of a medical specialist (i.e., ear doctor, allergist, orthodontist or psychologist)?  YES  NO

If YES, please explain: \_\_\_\_\_

Has your child had a physical exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Doctor:	Exam Date:
Has your child had an eye exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye Doctor:	Exam Date:
Does your child wear glasses or contact lenses at school?	<input type="checkbox"/> Yes <input type="checkbox"/> No	For Near, Far, At all times (circle one)	Exam Date:
Has your child had a dental exam within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dentist	Exam Date:
Does your child have a hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	Wears hearing aids <input type="checkbox"/> Yes <input type="checkbox"/> No	Audiologist	Exam Date:
Has your child had an operation and/or serious illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify:	

### HEALTH CONCERNS – LIFE THREATENING HEALTH CONDITIONS

If a life threatening health condition exists, a medication/treatment order from a Licensed Health Professional must be provided to your child's school prior to his/her attendance. If a health condition exists, an Emergency Care Plan may be developed by the District School Nurse.

My child **DOES NOT** have any health concerns.

**If there are health concerns, check all that apply:**

- ASTHMA Rescue Inhaler:  Yes  No Date last used: \_\_\_\_\_ Triggers? \_\_\_\_\_
  - ALLERGIES  Localized  Severe (Anaphylactic)
  - ALLERGY TYPE:  Food  Medication  Stinging Insect  Latex  Environmental  Other \_\_\_\_\_
  - List Allergies: \_\_\_\_\_ Treatment: \_\_\_\_\_
  - DIABETES:  Type 1  Type 2 Managed by:  Diet only  Oral meds  Insulin injections  Insulin pump
  - SEIZURE DISORDER Type of seizure: \_\_\_\_\_ Date of last seizure \_\_\_\_\_ Diastat:  Yes  No Lorazepam:  Yes  No Other: \_\_\_\_\_
  - CANCER/BLOOD DISORDER: Please specify: \_\_\_\_\_
  - ANOREXIA OR BULIMIA  KIDNEY DISEASE  ADD/ADHD  AUTISM  FREQUENT NOSEBLEEDS  FREQUENT HEADACHES
  - FREQUENT STOMACH ACHES  HEPATITIS  HEART CONDITION/DISEASE  RHEUMATIC FEVER  SERIOUS HEAD INJURY
  - OTHER HEALTH CONCERNS
- Please explain any items that you have checked: \_\_\_\_\_

Does your child have any other condition that might affect learning? \_\_\_\_\_

Does your child have a condition that requires special consideration in the classroom or for physical education? \_\_\_\_\_

Has there been any traumatic event in your family within the past 12 months that would affect your child's school experience adversely? \_\_\_\_\_

### MEDICATIONS

Prior to any medication given at school, a written authorization is required from a Licensed Health Professional and parent/legal guardian. **An Authorization for Administration of Medication form is available from the school office or on the district web site home page under Parent and Student, Student Health, Student Medication Administration Forms.**

Is medication needed at home?  Yes  No If yes, name of medication and condition \_\_\_\_\_

Is medication needed at school?  Yes  No If yes, name of medication and condition \_\_\_\_\_

**In the event of an emergency that requires medical treatment and/or hospitalization, the school is authorized to contact 911 and/or:**

Doctor Name: \_\_\_\_\_ Doctor Address: \_\_\_\_\_ Doctor Telephone: \_\_\_\_\_

Parent Telephone: \_\_\_\_\_ Emergency Contact Telephone: \_\_\_\_\_

*My signature grants permission for the school nurse to contact/discuss/review information regarding my child's medical care with the healthcare provider.*

Signature Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

	Name/Relationship	Phone Number
Contact #1:		
Contact #2:		
Contact #3:		