

## 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	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to:		
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Mild <input type="checkbox"/> Severe <input type="checkbox"/></li> <li>• Specify type and/or cause of asthma attack:</li> <li>• Takes daily medication <span style="float: right;"><input type="checkbox"/></span></li> <li>- If yes, specify: <span style="float: right;"><input type="checkbox"/></span></li> <li>• Takes emergency medication: <span style="float: right;"><input type="checkbox"/></span></li> <li>- If yes, specify: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
BEE STING ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Needs antihistamine tablet if stung <span style="float: right;"><input type="checkbox"/></span></li> <li>• Needs adrenalin injection if stung <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
DENTAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Has received dental care <span style="float: right;"><input type="checkbox"/></span></li> <li>• Date of last dental exam: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Tests blood routinely <span style="float: right;"><input type="checkbox"/></span></li> <li>• Has glucagon injection for insulin reaction <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/></li> <li>• Under doctor's care <span style="float: right;"><input type="checkbox"/></span></li> <li>• Date of last doctor's visit: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Takes daily medication <span style="float: right;"><input type="checkbox"/></span></li> <li>- If yes, specify: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Under doctor's care <span style="float: right;"><input type="checkbox"/></span></li> <li>• Specify any restrictions at school: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
ORTHOPEDIC PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Under doctor's care <span style="float: right;"><input type="checkbox"/></span></li> <li>• Specify any restrictions at school: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
SERIOUS INJURY NOW OR IN PAST	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
OTHER ILLNESS NOW OR IN PAST	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: <span style="float: right;"><input type="checkbox"/></span></li> <li>• Takes daily medication <span style="float: right;"><input type="checkbox"/></span></li> <li>- If yes, specify: <span style="float: right;"><input type="checkbox"/></span></li> <li>• Takes emergency medication <span style="float: right;"><input type="checkbox"/></span></li> <li>- If yes, specify: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
SURGERY/OPERATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
HAS HEALTH CONDITION WHICH PREVENTS PARTICIPATION IN REGULAR P.E.	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify condition and limitations: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
HAS TROUBLE SEEING AT A DISTANCE	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears glasses <span style="float: right;"><input type="checkbox"/></span></li> <li>• Wears contact lenses <span style="float: right;"><input type="checkbox"/></span></li> <li>• Date of last visit with eye doctor: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
HAS TROUBLE SEEING CLOSE UP	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears glasses <span style="float: right;"><input type="checkbox"/></span></li> <li>• Wears contact lenses <span style="float: right;"><input type="checkbox"/></span></li> <li>• Date of last visit with eye doctor: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
HAS TROUBLE HEARING	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears hearing aides <span style="float: right;"><input type="checkbox"/></span></li> <li>• Specify any needs at school: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		
OTHER HEALTH PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify problem and any medications: <span style="float: right;"><input type="checkbox"/></span></li> </ul>		