SIERRA-PLUMAS JOINT UNIFIED SCHOOL DISTRICT

Annual Health Inventory – 2021-2022

Child's Name: _____ Birthdate: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

Healthy children learn better. Knowledge of special conditions and/or concerns will help teachers and staff better meet your child's learning needs.

Please take the time to answer these questions carefully. A school nurse is available to discuss concerns.

ALL INFORMATION ON THIS FORM WILL BE KEPT CONFIDENTIAL

Medical Provider:_____ Date of last exam:_____

Dentist:_____ Date of last exam:_____

Is your child under the care of a medical specialist (i.e., Ear doctor, allergist, orthodontist or psychologist)?
If so, please explain:_____

Does your child take any medication ☐ Yes ☐ No List:_____

Will medication need to be given during school hours? ☐ Yes ☐ No

Please note: Any medication (including over the counter) that needs to be given at school requires written instructions by a medical provider on an authorized form and special arrangements with the school nurse.

Please indicate if your child currently or has a history of any of the following conditions:

☐ **No change in health from previous school year.**

☐ Allergies to bee stings, food, medications, or environmental agents: (Please explain: _____

_____ ☐ My child carries or uses an epinephrine auto injector.)

☐ Asthma	☐ Serious illness or injury	☐ Hepatitis	☐ Wears hearing aides
☐ Hearing problems	☐ Convulsions or seizures	☐ Rheumatic Fever	☐ Diabetes
☐ Frequent Headaches	☐ ADHD / ADD	☐ Frequent nosebleeds	☐ Frequent Stomach aches
☐ Serious head injury	☐ Heart disease	☐ Anorexia or bulimia	
☐ Surgery for serious illness/injury	☐ Kidney disease	☐ Wears glasses	

PLEASE EXPLAIN ANY ITEMS YOU HAVE CHECKED: _____

_____

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

_____

Does your child have any 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? _____

SOURCE OF HEALTH HISTORY INFORMATION

_____ **Date:** _____

(signature of person completing form)

☐ **Parent** ☐ **Guardian**

IF THERE IS ANY CHANGE IN THE CHILD'S HEALTH WHICH AFFECTS HER/HIS ABILITY TO TAKE PHYSICAL EDUCATION, OR IF SHE/HE IS PLACED ON REGULAR MEDICATION, (Educ. Code No. 49423) IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL. PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS.