Student number _____

# GARDEN GROVE UNIFIED SCHOOL DISTRICT

## STUDENT HEALTH INVENTORY

Child health is an important part of education. To better meet the health needs of your child, please complete.

**NOTE -** Medications at school, prescription or non-prescription, **requires doctor orders and parent signature.**

Student's name (Last)_____(First)_____(MI)_____ Male _____ Female_____

Birthdate _____ Place of Birth _____ Grade _____ School _____

Last School Attended (name, city, state) _____

**Check any health condition(s) listed below that your child has ever been diagnosed with and provide information:**

| Health Concern/Condition | Yes | No | | Health Concern/Condition | Yes | No |
|---|---|---|---|---|---|---|
| **Vision Impairment** | | | | **Hearing Loss** | | |
| Wears glasses (full time, part time, reading) | | | | Circle one: Right Ear Left Ear Both Ears | | |
| Wears contacts (day or night) | | | | Hearing Aid(s) | | |
| **ADD/ADHD** | | | | Circle one: Right Ear Left Ear Both Ears | | |
| Medication at school | | | | **Eating Disorder** Type _____ | | |
| **Allergies** | | | | **Endocrine Disorder** List type _____ | | |
| Food – List foods below | | | | **Epilepsy/Seizures** | | |
| Bee Stings | | | | Medication at school | | |
| Environmental (grass, dust, pollen, dander, seasonal, trees, etc.) List type below | | | | Last seizure date _____ | | |
| Medication at school | | | | **Gastrointestinal/Digestion Condition** | | |
| **Asthma** | | | | List type _____ | | |
| Medication at school | | | | **Headaches/Migraines** | | |
| **Autism** | | | | Medication at school | | |
| **Autoimmune Disease** Type_____ | | | | **Heart Disorder** Type _____ | | |
| **Bleeding Disorder** | | | | **Kidney/Bladder Condition** | | |
| List type _____ | | | | **Neurological Disorder** Type _____ | | |
| **Bone/Joint Disorder** | | | | **Psychiatric/Emotional Disorder** | | |
| **Cerebral Palsy** | | | | **Serious illnesses or injuries** | | |
| **Cystic Fibrosis** | | | | **Surgeries** | | |
| **Diabetes** Circle one: Type 1 Type 2 | | | | **Transplant** (bone marrow, organ, etc.) | | |
| Blood sugar testing at school | | | | **PE Modifications or Activity Restrictions** | | |
| Insulin at school | | | | ***Must have doctor's note*** | | |

| Medication | Dose | List times taken at home | Needed at School? | Purpose |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*(Continue on back if necessary)*

Explanations and additional comments: _____

_____

*(Continue on back if necessary)*

Parent Signature _____ Date _____