Henrietta Independent School District
Health Inventory

Dear Parent / Guardian:
Please return this completed form to the school office. The information given will enable the school staff to have a better understanding of the health status of your child.

Student Name:	**Birth Date:**	**Sex:**
Address:	**Grade:**	**Teacher:**
Medication Allergies:	**Food/Environmental Allergies:**	

MEDICAL HISTORY: (Please check all that apply, and give date of initial diagnosis.)

Behavior Problems:
- ☐ ADD/ADHD
- ☐ Depression

Brain:
- ☐ Cerebral Palsy
- ☐ Seizure Disorder

Cardiac / Vascular:
- ☐ Anemia
- ☐ Heart disease
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Leukemia
- ☐ Rheumatic Fever
- ☐ Sickle Cell Trait
- ☐ Sickle Cell Disease

Communicable Diseases:
- ☐ Chicken Pox (DATE:)_____
- ☐ TB – Contact
- ☐ Others not listed:_____ _____

Eyes/Ears/Nose/Throat:
- ☐ Blindness
- ☐ Cataracts
- ☐ Cochlear Implant
- ☐ Detached Retina
- ☐ Hearing Aid(s)
- ☐ Hearing Loss
- ☐ Strabismus
- ☐ Glaucoma

Gastrointestinal:
- ☐ Bowel "problems" _____
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis – Type _____
- ☐ Irritable Bowel Syndrome

Other:
- ☐ Cancer – Type:_____ _____
- ☐ Surgery – Type_____ _____
- ☐ Serious Accident -_____ _____

Orthopedic:
- ☐ Kyphosis (Hump Back)
- ☐ Lordosis (Sway Back)
- ☐ Muscular Dystrophy
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Fractures

Respiratory:
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ Allergy –Severe
- ☐ Allergy – Seasonal

- ☐ Kidney Disease
- ☐ Lupus
- ☐ Diabetes
- ☐ Insulin Pump

Is your child currently under medical care? ☐Yes or ☐ No. If yes, for what condition?
_____

Is your child currently on any medications? ☐Yes or ☐ No. If yes, please list.
_____

Signature of Parent/Guardian _____ Date:_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone( ) _____

Signature of Parent/Guardian _____ Date:_____

Home Phone ( )_____ Work Phone ( )_____ Cell Phone( ) _____

IN THE EVENT THAT THE PARENT/GUARDIAN CANNOT BE REACHED, CALL:

NAME:	**RELATIONSHIP:**	**HOME PHONE:**
		WORK PHONE:
NAME:	**RELATIONSHIP:**	**HOME PHONE:**
		WORK PHONE:
STUDENT PHYSICIAN:		**OFFICE PHONE:**
STUDENT DENTIST:		**OFFICE PHONE:**

*** Please contact the school nurse to update this information as needed.**