ONTARIO-MONTCLAIR SCHOOL DISTRICT
HEALTH SERVICES
HEALTH INVENTORY

DATE _____

Last	First	☐M ☐F Gender	Date of Birth	Place of Birth

Address	City, State	Phone

Last School Attended	City, State	Previous Ontario-Montclair District School Attended

Name of family physician or health plan _____ Birth weight _____

Child lives with ☐ Father ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grandparent

Father's Name _____ Mother's Name _____

ILLNESS

	Yes	No
• Chickenpox	☐	☐
• German Measles (3 days)	☐	☐
• Red Measles (10 days)	☐	☐
• Scarlet Fever	☐	☐
• Earache	☐	☐

MEDICAL/HEALTH PROBLEMS

(If yes, please explain below)

• Vision	☐	☐
• Wears glasses	☐	☐
• Dental	☐	☐
• Hearing	☐	☐
• Uses hearing aids	☐	☐
• Heart	☐	☐
• Lungs	☐	☐
• Kidney/Bladder	☐	☐
• Bone/Joint	☐	☐

If yes to any of the above, please explain _____

Other physical disability? _____

List ALL medications now being taken? _____

ALLERGIC/CHRONIC DISEASES

	Yes	No
• Allergic reaction to insect sting	☐	☐
SEVERE _____ Mild _____		
• Any other allergies	☐	☐
If so, please explain _____		
List all medications for allergies _____		
• Asthma	☐	☐
• Diabetes	☐	☐
• Seizures	☐	☐
• Epilepsy	☐	☐

If yes to any of the above, please explain _____

LIST BELOW THE YEAR ANY OF THESE OCCURRED

- Serious injuries/illnesses/accidents? (Explain and list dates) _____
- Any surgeries? (Explain and list dates) _____
- Any hospitalizations (Explain and list dates) _____
- Tuberculosis Test _____ ☐Positive ☐ Negative
- Date of most recent complete physical exam _____
- Does your child have any learning problems? ☐ Yes ☐ No
  If yes, please explain _____

Other health information that may be helpful to the school nurse _____