Stanislaus County
Office of
Education

Tom Changnon, Superintendent

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STUDENT HEALTH INVENTORY

Grade: ____________

School ______________________ Date ____________

Name ______________________ (Last / First / Middle) M ___ F ___ (Gender) Birth Date ____________

Language spoken at home: ____________

Birth History (circle Yes/No):

Child was what number pregnancy? ________ Number of living children? ________

Was the mother under medical care during the prenatal period? Yes/No

Did mother use any drugs, alcohol or tobacco during pregnancy? Yes/No

Explain ____________

Normal Birth? Yes/No Length of Labor? ________ C-Section? Yes/No Forceps? Yes/No

Was child full term? Yes/No Premature? Yes/No How much? ________ Birth weight? ________

Was there any breathing difficulty for the child? Yes/No Oxygen given? Yes/No

Did mother and child come home from the hospital together? Yes/No

If "no," give reason: ____________

When did child: Sit alone? ________ Walk alone? ________ Talk? ________ Toilet Trained? ________

Past & Present Medical Issues: (Check all that apply):

		Comments:			Comments:
______	Asthma	______	______	Heart Disease	______
______	ADD/ADHD	______	______	Hepatitis	______
______	Bone/Joint Problems	______	______	Kidney Disease	______
______	Chicken Pox	______	______	Rheumatic Fever	______
______	Diabetes	______	______	Scarlet Fever	______
______	Ear Problems	______	______	Seizures	______
______	Eye Problems	______	______	Skin Problems	______
______	Frequent Colds	______	______	Speech Problems	______
______	Head Injury	______	______	Stomachaches	______

______ Allergy (if so, to what?) ____________

Other serious illnesses, operations, injuries, hospitalizations and age of occurrence: ____________

____

CURRENT HEALTH STATUS (CIRCLE YES/NO):

Doctor? Yes/No Name ________ Date of exam ________ Recommendations ________

Dentist? Yes/No Name:________ Date of exam ________ Recommendations ________

Eye Doctor? Yes/No Name: ________ Date of exam ________ Recommendations ________

Ear Doctor? Yes/No Name: ________ Date of exam ________ Recommendations ________

Is your child under a doctor's care now? Yes/No Name: ____________

If yes, for what condition?________ Recommendations ____________

If your child is taking medication: Name ________ Dose: ________ Frequency Given: ________

____

Do you have: (Circle One) Medi-Cal / Private / Self-pay insurance?

(OVER)

Family and Social History

Is this child's mother living? ______ Age ______________ In good health? ____________
Is this child's father living? _______ Age ______________ In good health? ____________

Has any family member (sisters, brothers, aunts, uncles, grandparents) had any of the following:

________Allergies (asthma, Hay fever) ______________
________Convulsions or Epilepsy ______________
________Diabetes ______________
________Mental Retardation/Slow Learner ______________
________Any inherited Diseases ______________
________Has a parent, brother or sister died? ______________________________________
Relationship cause of death age at death

Which of the following have you observed in your child? Please check:

- ❑ Plays well with other children
- ❑ Shares with others
- ❑ Seeks friends
- ❑ Is withdrawn
- ❑ Stumbles or drops things often
- ❑ Angers easily
- ❑ Discourages easily
- ❑ Is distrustful
- ❑ Has fears or worries
- ❑ Cries easily
- ❑ Thumb sucking
- ❑ Nail biting
- ❑ Bed wetting
- ❑ Overactive
- ❑ Follows instruction

What behavior management is most effective with your child? ______________________________

What activity does your child enjoy most? ____

Any other information which might help the school to understand and work with you and your child: _______

____

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 A REGULAR MEDICATION, (Educ. Code No. 49423) IT IS THE PARENTS' RESPONSIBILITY TO NOTIFY THE SCHOOL. PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS

Family Members (Including Parents/others living in the home)

Name	Sex	Birthplace	Birth Date	Relationship to Child	Occupation or Grade

____
Source of History Information

____
Signature of person completing form

❑Parent ❑Guardian ❑Other __________