



**Mrs. Brenda Davidson**  
Headmaster

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**HEALTH INVENTORY**

STUDENT'S NAME: \_\_\_\_\_ SEX \_\_\_\_\_ DOB \_\_\_\_\_

BIRTH WEIGHT: \_\_\_\_\_ PREMATURE?: NO / YES: How many weeks? \_\_\_\_\_  
(Circle one)

DISEASE HISTORY	AGE	DISEASE HISTORY	AGE	DISEASE HISTORY	AGE
Asthma		Heart Disorder		Surgery/Fractures	
Blood Disorder		Kidney Disorder		T. B. Contract	
Cancer		Orthopedic		Hearing Loss	
Convulsions		Poliomyelitis		Vision Loss	
Diabetes		Rheumatic Fever		Chickenpox	
Epilepsy		Serious Accident		Other	
Bronchitis		Pneumonia		Other	
If this Student has had any of the above conditions, did he/she receive medical care?				NO	/ YES
Is the student under treatment now?				NO	/ YES

Please check any of the signs or symptoms listed below you have recently observed:					
Tires Easily		Frequent sore throats		Nail Biting	
Underweight		Frequent nose bleeds		Restlessness	
Overweight		Earaches		Shyness	
Frequent headaches		Fainting		Does not like school	
Frequent colds		Frequent stomach aches		Emotional upsets	
Urinary accidents		Bowel accidents		Does not get along with others	
Has the student consulted a physician about the above symptoms?				NO	/ YES
Physician's Name:			Consult Date:		

Has the student had a complete physical exam?	NO	YES: when?
Is the student on any kind of medication? For what condition(s):	NO	YES: what?
Is the student under medical care at this time?	NO	YES
Name of doctor:		Phone:
Please list special needs or abnormalities:		
Please list known allergies:		
Further comments:		

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_  
 Revised 1/08

DATE \_\_\_\_\_