GALENA PARK INDEPENDENT SCHOOL DISTRICT

Health Inventory – Elementary and Secondary

School: ____________________________________ Homeroom/Teacher: ___________________________

Parent/Guardian: Please fill in this form and return to the teacher or nurse at the earliest possible date. Please be aware that the information given on this form may be shared with appropriate school staff in order to have a better understanding of the health status of your child.

Name: _____________________________ Sex: M: ___ F: ___ DOB: ___________ Birth Wt.: ________

DISEASE HISTORY	YES	NO	DISEASE HISTORY	YES	NO
Allergy (specify)			Muscular Dystrophy		
Asthma (specify)			Eating Disorder		
ADD/ADHD			Headaches		
Autism			Arthritis		
Brain Injury			School Phobia		
Cancer			Seizures		
Heart/Cardiovascular Disease			Spina Bifida		
Ear Infections/Hearing Problems			Orthopedic		
Cerebral Palsy			Supplemental Oxygen		
Cystic Fibrosis			Tourette's Syndrome		
Depression			Ventriculo-Peritoneal Shunt		
Diabetes			Bladder/Kidney Infections		
Down's syndrome			Vision Problems		

*Surgeries/Other Condition: ____

* Is your child under a doctor's medical care for any of the above mentioned conditions? YES _____ NO _____

* Restrictions due to above condition: ____

* Is your child on any kind of medication? YES _____ NO _____ If so what? ______________________________

* For what condition? _______________________________ Name of doctor or clinic:_____________________________

*Is your child allergic to any food? YES_____NO_____ If so, which food(s)?____________________________________

Is there any thing special you wish to bring to our attention ? ____
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****What type of insurance do you have for this child?**

____CHIP ____Medicaid ____Harris County Hospital District Medical Card _____Private Insurance ____None

I give my permission for the school nurse to instruct my child's teacher and others in the care of my child, on his/her medical conditions so they can observe for any complication that might occur. I also give my permission for the school nurse to request medical/health information or immunization records and/or communicate with the doctor's office regarding this information.

Parent's Signature: __________________________________ Date: ________________________

******** Please return this form to school nurse within 10 days. ********