Culbertson Public School, Student's Health Inventory

Student's Name:_____ Birth Date:_____ Male_____ Female_____

Doctor's Name:_____ Phone No.:_____

Please answer the following questions: Your student's learning depends upon good health. Please complete all information.

Has this student had any serious physical injuries? _____ If yes, explain:_____
Does this student have any physical limitations or motor impairments? _____ If yes, explain:_____
_____

Does this student wear glasses or contact lenses? _____

Does this student have any hearing issues? _____ If yes, please explain:_____

Does this student have allergies to drugs, food or other? _____ Please list:_____
Has the allergy required emergency action in the past? Yes_____ No_____
Symptoms:_____
How soon does it occur after contact (length of time):_____
Does it need emergency medication? Yes_____ No_____ If yes, what kind?_____
Does this student know the symptoms? Yes_____ No_____

Does this student have bee/wasp sting allergy? Describe reaction:_____
Difficulty breathing? Yes_____ No_____
Does this student know the symptoms? Yes_____ No_____
How soon do symptoms occur after being stung? _____
Need emergency medication? Yes_____ No_____ If yes, what kind?_____

Does this student have asthma? Yes _____ No _____ Describe reaction:_____
Triggered by:_____ Usually Occurs:_____
Symptoms:_____
Treatment:_____

Please list names of medication and reason for taking:_____
_____

is there any other health information or concerns we should be aware of in caring for your child:
Yes_____ No_____ If yes, please explain:_____
(If you need additional spacing for writing, please use back and attach any additional pertinent information you deem necessary.)

I understand and agree that any health information pertinent to my child's safety at school will be shared with appropriate school personnel.

Parent/Guardian Signature:_____ Date_____