

**Orange Unified School District  
Student Health Inventory**

Date \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_

Student Name \_\_\_\_\_ Male  Female   
*Last First Middle*

School Last Attended \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

HEALTH STATUS	NO	YES	DESCRIBE IF YES	NO	YES
ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	Allergic to:		
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Mild <input type="checkbox"/> Severe <input type="checkbox"/></li> <li>• Specify type and/or cause of asthma attack: _____</li> <li>• Takes daily medication: <input type="checkbox"/> <input type="checkbox"/></li> <li style="padding-left: 20px;">○ If yes, specify:</li> <li>• Takes emergency medication: <input type="checkbox"/> <input type="checkbox"/></li> <li style="padding-left: 20px;">○ If yes, specify:</li> </ul>		
BEE STING ALLERGY	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Needs antihistamine tablet if stung</li> <li>• Needs adrenalin injection if stung</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
DENTAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Has received dental care</li> <li>• Date of last dental exam: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Tests blood routinely</li> <li>• Has glucagon injection</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
EAR INFECTIONS	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Occasionally <input type="checkbox"/> Frequently <input type="checkbox"/></li> <li>• Under doctor's care:</li> <li>• Date of last doctor's visit: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Takes daily medication</li> <li>• If yes, specify: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
HEART CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Under doctors care</li> <li>• Specify restrictions at school: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
ORTHOPEDIC PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Under doctors care</li> <li>• Specify any restrictions at school: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
SERIOUS INJURY NOW OR IN PAST	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: _____</li> </ul>		
OTHER ILLNESS NOW OR IN PAST	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: _____</li> <li>• Takes daily medication <input type="checkbox"/> <input type="checkbox"/></li> <li style="padding-left: 20px;">○ If yes, specify: _____</li> <li>• Takes emergency medication <input type="checkbox"/> <input type="checkbox"/></li> <li style="padding-left: 20px;">○ If yes, specify: _____</li> </ul>		
SURGERY/OPERATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify: _____</li> </ul>		
HAS HEALTH CONDITION WHICH PREVENTS PARTICIPATION IN REGULAR P.E.	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify condition and limitations: _____</li> </ul>		
HAS TROUBLE SEEING AT A DISTANCE	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears glasses</li> <li>• Wears contact lenses</li> <li>• Date of last visit with eye doctor: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
HAS TROUBLE SEEING CLOSE UP	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears glasses</li> <li>• Wears contact lenses</li> <li>• Date of last visit with eye doctor: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
HAS TROUBLE HEARING	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Wears hearing aids</li> <li>• Specify any needs at school: _____</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER HEALTH PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<ul style="list-style-type: none"> <li>• Specify problem and any medications: _____</li> </ul>		