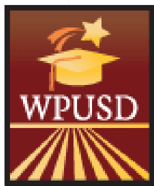

Western Placer Unified School District
600 Sixth Street, Suite 400, Lincoln, CA 95648 Ph: 916-645-6350

Health Inventory

2014-2015 School Year

Student Name: ______________________ ______________________ **School:**______________________
Last First **Grade:**____________

☐ **Please check here if there are no known health problems or concerns.**

VISION	**HEARING**
☐Known eye condition Specify: ______________________ ☐Wears glasses ☐At all times ☐Reading only ☐Wears contacts ☐Color blind Date of last exam: _____/_____/_____	☐Permanent hearing loss ☐Hearing aid ☐Left ☐Right ☐Both ☐Frequent Infections ☐Past ☐Present Date of last exam: _____/_____/_____

Does medication need to be administered during school hours? ☐**Yes*** ☐**No**

Student has the following conditions: (please attach additional page if necessary and check here ☐)

	Medication and Dosage prescribed by medical provider:	Additional Information:
☐ADD/ADHD ☐Requires Medication		☐Required at school*
☐Allergies ☐Seasonal ☐Food** ☐Environmental ☐Other	Allergic to:____ ☐Breathing difficulty ☐Hives/Rash ☐EpiPen or AuviQ	
☐Asthma ☐Requires inhaler/Medication	☐Daily ☐As needed ☐With exercise	☐Required at school*
☐Diabetes** ☐Type 1 ☐Type 2 ☐Requires Medication	☐Oral ☐Injected ☐Pump	☐Required at school*
☐G-Tube ☐Requires Medication		☐Required at school*
☐Heart Condition ☐Requires Medication ☐Physical Limitations		
☐Orthopedic Condition	☐Wheelchair ☐Crutches ☐Corrective shoes/braces ☐Other:____	☐Physical Therapy
☐Seizure Disorder** ☐Requires Medication	Date of last seizure:_____/_____/_____ How often:______________________ Types of seizures:______________________________ Medication taken:______________________________	
☐Other health concern ☐Requires Medication	Diagnosis:______________________ Date of diagnosis:__________________ Comments:	
☐Hospitalization	Explain:	Date:

* A current signed Physician's Authorization for Medication in School form must be on file in the health office for any student taking medication (physician prescribed or over the counter) during school hours. **This release must be renewed yearly.**
** **These conditions require a Health Care Plan.** Any of the above conditions may require a Health Care Plan. All forms may be obtained from the school office or on the districts website under the parent resources tab.

Would you like the district nurse to address your child's medical condition with a Health Care Plan? ☐Yes ☐No

Parent/Guardian Signature:____ Date:________________

Reviewed by Clerk:________________________ Date:____/____/____
(Clerk: file in health cum if no above concerns. If concerns give to RN for review)

District Nurse:__________________________ Date:____/____/____ Follow up:__________________