HEALTH INVENTORY FORM

School Health Nursing Staff **Chariton County Health Center**

Please complete. This information is used to contact you if your child becomes ill or injured during school hours. All information is confidential and will only be shared with faculty as is absolutely necessary.

Grade _____ **Teacher** _____

Student Name _____ Sex ____ Birthdate _____
Last First MI

Address _____ Home Phone _____
Street/PO Box City Zip

Parent/Guardian Name _____ **Parent/Guardian Name** _____

Contact Number: _____ Contact Number: _____

Employer(s) _____ Phone(s) _____

E-mail Address: _____

Student Cell Phone: _____

Physician's Name _____ Physical Exam in past 12 Months? Yes ___ No ___ Month _____Year _____

Dentist's Name _____ Dental Exam in past 12 Months? Yes ___ No ___ Month _____Year _____

Eye Care Provider: _____ Eye Exam in past 12 Months? Yes ___ No ___ Month _____Year _____

Does your child have health insurance? Yes ☐ No ☐ **Medicaid/MC+? Yes ☐ No☐**

(Please indicate your child's health insurance. If your child has no health insurance or this section is left blank, you will receive information on MC+ For Kids.)

Neighbor or Relative to be called in case parents/guardians cannot be reached:

Name _____ Phone _____

Name _____ Phone _____

Does your child have any allergies to medicine or foods? Yes ☐ No ☐ If YES, to what and describe reaction

Does your child have any health problems or medication that the nurse/teacher should be aware of? Yes ☐ No ☐
If the answer is "YES", please specify. (use back of sheet if needed)

Please list type and date of any immunizations(vaccines or shots)/surgeries/hospitalizations since school dismissal in May

NOTE: No medicine of any kind can be given at school unless supplied by parent and accompanied by written permission and instruction. All medication must be brought to school by parent/guardian.

_____ _____
Parent/Guardian Signature Date

***PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE WITH YOUR CHILD BEFORE AUGUST 31, 2017**