

**HOUSTON INDEPENDENT SCHOOL DISTRICT
School Health Department**

HEALTH INVENTORY

SCHOOL _____

DATE _____

TEACHER

Please fill in this form and return it to the teacher or nurse at the earliest possible date. The information given on this form will enable the school staff to have a better understanding of the pupil's health status.

Name _____ Sex _____ Birthdate _____ Birth weight _____

Address _____ Phone _____

Disease History	Age	Disease History	Age
Asthma		Orthopedic	
Allergy		Poliomyelitis	
Blood Disorder		Rheumatic fever	
Convulsions		Serious accident	
Diabetes		Surgery/fractures	
Epilepsy		T.B. contact	
Heart disease		Hearing loss	
Kidney disorder		Vision loss	

If this pupil has had any of the above conditions did he/she receive medical care? Yes _____ No _____

Is he/she under treatment now? Yes _____ No _____

Please check any of the following signs and symptoms you have recently observed.

- | | | |
|---|---|---|
| <input type="checkbox"/> Tires easily | <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Nail biting |
| <input type="checkbox"/> Underweight | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Earaches | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Does not like school |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent stomach-aches | <input type="checkbox"/> Does not get along with others |

Has the pupils consulted a physician about the above symptoms? Yes _____ No _____

Has the pupil had a complete physical in the past year? Yes _____ No _____

Is this pupil on any kind of medication? _____

If so, what? _____

For what condition? _____

Is this pupil under medical care at this time? _____

Name of doctor or clinic _____

Further comment _____

Has the pupil ever attended the Houston Public Schools? _____

Name of School _____ Date attended _____

PLEASE FEEL FREE TO CONSULT WITH THE SCHOOL STAFF ABOUT HEALTH PROBLEMS.

Signature _____