School:_____ *Springfield Public Schools* Student #:_____

Grade:_____ **STUDENT HEALTH INVENTORY**

Student's Name:_____Date of Birth:_____ Sex:_____

Emergency Contact Name: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Has student <u>previously</u> attended <u>another</u> Public School? ____ No ____Yes→_____

Name of school OR previous program

For concerns, please check "yes" or "no" and if yes, provide a comment:

CONCERN	YES	NO	COMMENTS	CONCERN	YES	NO	COMMENTS
ADD/ADHD	☐	☐		Developmental Delay	☐	☐	
Allergies (food, insects, latex, other)	☐	☐		Diabetes	☐	☐	
Allergies (environmental, seasonal, meds)	☐	☐		Genetic Disorder	☐	☐	
Assistive Devices	☐	☐		Head Injury/Concussion/TBI/ABI	☐	☐	
Asthma (history or under treatment)	☐	☐		Hearing (aids/FM device)	☐	☐	
Autism	☐	☐		Heart (not innocent murmur)	☐	☐	
Behavioral and/or Emotional	☐	☐		Migraines	☐	☐	
Bladder	☐	☐		Neuromuscular (cerebral palsy, muscular dystrophy)	☐	☐	
Bleeding	☐	☐		Nutrition (feeding issues)	☐	☐	
Bone or Joint Problems	☐	☐		Seizures (history of or under treatment)	☐	☐	
Bowel	☐	☐		Sickle Cell Disease or Trait	☐	☐	
Cancer (history or under treatment)	☐	☐		Speech	☐	☐	
Cystic Fibrosis	☐	☐		Surgeries: (please list)	☐	☐	
Dental	☐	☐		Vision (glasses/contacts/blind)	☐	☐	

Additional information regarding your child's health:_____

Does your child take medication (prescription or over-the-counter) **for any of the above concerns?**

_____No _____Yes→(Name of medication(s)/reason for taking) _____

*****Medication to be taken at school requires additional forms. Contact school nurse for policy guidelines.**

Does your child require any special procedures? (catheterization, ostomy care, suctioning, tube feeding, diapering, etc?)

_____No _____Yes→(describe)_____

Provider	Name	Approx. date of last visit
Pediatrician/Primary Care Provider		
Specialist		
Hospital Preference		
Dentist/Orthodontist		
Outside Counseling; PT; OT; or Speech		
Case Worker (if applicable)	Phone Number	

Health Insurance ____None ____Private Health Insurance ____Medicaid (MoHealthNet)→_____

SPECIAL EDUCATION or **SERVICES** student receives: ☐ IEP ☐ 504 ☐ Dietary 504 ☐ Modified PE ☐ PT ☐ OT

Transportation to/from school: ____Walk ____Car ____Bus (#_____) _____Daycare (_____)

Name of daycare/program

I understand if my child is injured or becomes seriously ill and the school nurse, principal or designee cannot notify me by telephone, they will secure medical attention for my child and use ambulance services if necessary. I also understand that I will be responsible for the costs of such medical services and care.

Name of legal parent/guardian_____Relationship_____Date_____

Revised 3/13/17