HEALTH INVENTORY

Name of Child _____ Date of Birth _____

School _____ Grade _____

Check if appropriate:

_____ Wears glasses

_____ Hard of hearing

_____ Frequent ear infections

_____ Frequent urination

_____ Speech difficulty

_____ Diabetes

_____ Epilepsy

_____ Fainting spells

_____ Hernia

_____ Heart disease

My child has had the following:

_____ Chickenpox

_____ Scarlet fever

_____ Pneumonia

_____ Tuberculosis contact

_____Diphtheria

_____ Mumps

_____ Measles (3 day)

_____ Measles (10 day)

_____ Strep throat

_____ Ear infection

_____ Whooping cough

_____ Poliomyelitis

_____ Rheumatic fever

_____ Tonsil/Adenoidal removal

_____ Severe/Crippling conditions

Allergies (please explain): _____

_____

Limiting physical condition (please explain): _____

_____

Medical advisor _____ Last check-up _____

Address _____ Phone _____

Special health conditions (please explain): _____

_____

_____

Additional comments: _____