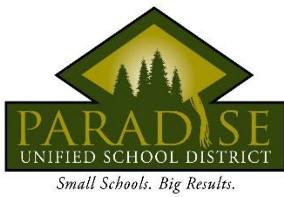

Paradise Unified School District
Student Health Inventory

______________________ Name of School

______________________ School Year

______________________ Student Name (please print)

__________ Grade Level

____/____/______ Date of Birth (i.e. 10/15/2001)

1. Student's current/previous health conditions:

- ☐ ADD or ADHD
- ☐ Allergy to insect stings*
- ☐ Allergy to food*
- ☐ Allergy-other*
- ☐ Asthma*
- ☐ Diabetes
- ☐ Emotional/behavioral concerns
- ☐ Gastrointestinal disorder
- ☐ Head injury
- ☐ Heart condition
- ☐ Kidney condition
- ☐ Neurological condition
- ☐ Orthopedic condition
- ☐ Seizures
- ☐ Surgery
- ☐ Other: ____________________

Please explain all checked items above and complete reverse side for any starred (*) items:

____

____

2. Does your child have any current health conditions? ☐ Yes ☐ No

If yes, please explain: ____

____

3. Is your child currently under a doctor's treatment for any reason? ☐ Yes ☐ No

If yes, please explain: ____

____

4. Is your child taking any medication regularly? ☐ Yes ☐ No

If yes, what is the name of the medication(s)? ______________________________

What is the purpose of the medication(s)? ______________________________

If yes, is the medication taken during the school day? ☐ Yes ☐ No

If yes, please list which medications are taken at school: ______________________

____

5. Ears/Hearing:

- ☐ Physician verified hearing impairment
- ☐ Wears hearing aid(s)
- ☐ Other: ______________________________

Please explain any checked items above: ______________________________________

____

6. Eyes/Vision:

- ☐ Eye or vision condition
- ☐ Eye surgery

Other:

- ☐ Wears glasses
- ☐ At school with student
- ☐ To be worn at all times
- ☐ Wears contact lenses
- ☐ To be worn for close work only
- ☐ To be worn for distance only

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Complete these sections only if you checked starred (*) items on the front side of this form.

Asthma/Allergies

1. Does your child have: ☐ Asthma ☐ Allergies

If yes, does your child take medication at home? ☐ As needed ☐ On a regular basis ☐ No

***If there is a need to take medication at school, please bring the medication with the doctor's written request and directions to the school health office as soon as possible.**

2. If allergies, please list: ____

3. Has your child ever had a life-threatening reaction to a food or other substance? ☐ Yes ☐ No

Please list the food(s) and/or substance(s): ____________________________________

4. Bee Sting Allergy

Has the swelling been limited to the area around the bee sting? ☐ Yes ☐ No

Is oral medication kept at home to take in case of a bee sting? ☐ Yes ☐ No

Should medication be kept at school? ☐ Yes ☐ No

Does the reaction require that an injection medication be given immediately if stung? ☐ Yes ☐ No

*__If yes, please contact the school's Health Secretary to obtain the information and paperwork necessary to have an injectable medication at school.__

***If there is a need to take medication at school, please bring the medication with the signed physician's authorization to the school health office as soon as possible.**

AUTHORIZATION FOR TREATMENT OF MINOR

(I/We), the undersigned, parent(s)/guardian(s) of ____,
Print student's full name

a minor, do hereby authorize Paradise Unified School District as agent for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medically staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain effective until revoked in writing and delivered to said agent.

________________________________ Date: ________________ Phone: __________________
Signature of father/legal guardian

________________________________ Date: ________________ Phone: __________________
Signature of mother/legal guardian

***Please do not hesitate to contact your school's Health Secretary regarding any of your child's health concerns and/or if you need assistance obtaining medical or dental care for your family members.**