Humboldt County Office of Education

Annual Health Inventory

Student Name: _____ Grade Level: _____ Date of Birth: _____

HEALTH PROBLEMS *(Please check all that apply.)*

☐ Asthma — Rescue inhaler? ☐ Yes ☐ No At school? ☐ Yes ☐ No Hospitalization? ☐ Yes ☐ No Last date_____

☐ Seizure disorder/epilepsy — Type and description of seizure: _____ Date of last seizure: _____

☐ Diabetes — ☐ Type 1 ☐ Type 2 Managed by: ☐ Diet only ☐ Oral meds ☐ Insulin injection ☐ Insulin pump ☐ CGM

☐ History of heart problem — Describe: _____

☐ History of hospitalization/surgery — Describe/date: _____

☐ Known vision loss — ☐ Right ☐ Left Describe: _____

☐ Wears contact lenses/glasses — Please check one: ☐ For reading only ☐ For distance only ☐ At all times

☐ Known hearing loss — ☐ Right ☐ Left Describe: _____

☐ Wears hearing aide — ☐ Right ☐ Left Describe: _____

☐ Other medical condition(s) or other/further details on conditions above:

☐ Restrictions on physical activity: _____

☐ Other medical restrictions: _____

☐ Allergies — List specific item(s) student is allergic to: _____

Describe allergic reaction and treatment:

Has emergency allergy medication been prescribed? ☐ Yes ☐ No

CURRENT MEDICATION(S) (If medication taken during school hours, please complete a Consent of Medication form.)

If yes, name of medication(s)	Dosage	Time taken	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Signature:_____ Date: _____