East Valley School District #361
Health Inventory

The information provided will be reviewed by a school nurse and may be shared with your student's teacher(s), the school secretaries, and any other school personnel who have a need to know in order to maintain safety at school. If you have any questions, please contact the school nurse.

Last Name:		First Name:		Gender:	**M F**	Birthdate:	
School:		Teacher:		Grade			
Parent/Guardian:		Home phone:		Cell Phone:			
Emergency Contact:		Home phone:		Cell Phone:			

Section A: My student does not have any health concerns: ☐ *(If checked skip to section B)*

ADD/ADHD	☐ Yes ☐ No	Medication: ☐ Medication at School
Allergies	☐ Yes ☐ No	Specify: ☐ Food Intolerance ☐ EpiPen
Bee sting allergy	☐ Yes ☐ No	Notes: ☐ Local reaction ☐ EpiPen
Asthma	☐ Yes ☐ No	Notes: ☐ Inhaler at school
Blood disorder	☐ Yes ☐ No	Specify:
Cancer	☐ Yes ☐ No	Specify:
Developmental concern	☐ Yes ☐ No	Specify:
Diabetes	☐ Yes ☐ No	Notes:
Epilepsy or Seizures	☐ Yes ☐ No	Date/type last seizure:
Gastrointestinal concern	☐ Yes ☐ No	Specify:
Heart condition	☐ Yes ☐ No	Specify:
Headaches	☐ Yes ☐ No	Notes: ☐ Migraines
Mental health condition	☐ Yes ☐ No	Specify:
Musculoskeletal concern	☐ Yes ☐ No	Specify:
Urinary system concern	☐ Yes ☐ No	Specify:
Other	☐ Yes ☐ No	Specify:

Section B: Has your student had?

Serious illness/injury	☐ Yes ☐ No	Type & date:
Concussion	☐ Yes ☐ No	Cause & date:

Section C: Does your student have?

Wear glasses or contacts	☐ Yes ☐ No
Wear hearing aid(s)	☐ Yes ☐ No

Section D: Does your student?

Have an IEP or 504 plan?	☐ Yes ☐ No	Specify:
Have any medical or physical restrictions	☐ Yes ☐ No	Specify:
Ride a bus	☐ Yes ☐ No	

I give permission for my child's school to add immunization information into the Immunization Information System ☐ Yes ☐ No

A signed Doctor/Parent Permission Form is required for students needing medication at school.
Please obtain necessary paperwork from the office.

Parent Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

RN Signature: _____ Date: _____