PARENTS – PLEASE FILL OUT

SPRINGFIELD PUBLIC SCHOOLS

Student Health Inventory

Grade_____

Name_____ School_____

Address_____ Boy___Girl___Birthdate_____

Date of Last Physical Exam_____ Date of Last Dental Exam_____

Doctor's Name _____ Dentist's Name_____

DOES YOUR CHILD HAVE:	Yes/No		Yes/No
Allergies?	_____	Back, or spine injury?	_____
Asthma?	_____	Sickle Cell trait?	_____
Bee sting allergy?	_____	Skin condition?	_____
Diabetes?	_____	Enlarged liver/spleen?	_____
Ear infections?	_____		

HAS YOUR CHILD HAD:

Epilepsy or seizures?	_____	Serious illness?	_____
Heart condition?	_____	Serious injury?	_____
Bone or joint problem?	_____	Surgery (operation)?	_____
Behavioral problems?	_____	Childhood diseases?	_____
Alcohol or illicit drug use?	_____		

DOES YOUR CHILD:

High blood pressure?	_____	Have trouble seeing?	_____
Hernia?	_____	Seeing at a distance?	_____
Absent testicle, ovary, kidney, or eye?	_____	Wear glasses?	_____
Birth defect or deformity?	_____	Wear contact lenses?	_____
Concussion?	_____	Have trouble hearing?	_____
Wear a hearing aid?	_____		

Is your child under the care of an orthodontist? Yes ____ No____
Is your child on any medication on a regular basis? If so, please list,
_____
Please explain any questions marked YES _____
_____

This information is accurate to the best of my knowledge. I certify that my son/daughter is not under the regular care of a physician for heart condition, asthma, epilepsy, or other chronic condition requiring special care. I acknowledge that the screening test being performed on my child is not a complete examination and cannot guarantee that all conditions affecting his/her safety can be detected by this simple screening procedure.

Parent Signature_____ Date_____