Houston Independent School District
Health and Medical Services

Health Inventory

School: _____ Date: _____

Teacher: _____ Grade: _____

Please fill in this form and return it to the teacher or nurse at the earliest possible date. The information given on this form will enable the school staff to have a better understanding of the pupil's health status.

Name: _____ Sex: _____ Birthdate: _____ Birth weight: _____

Address: _____ Phone #: _(_____)_____

Cell Phone #: _(_____)_____

Disease History:

	AGE		AGE		AGE
❑ Asthma	____	❑ Heart Disease	____	❑ Sickle Cell Disease	____
❑ Allergy	____	❑ Kidney Disorder	____	❑ Surgery/fractures	____
❑ Blood Disorder	____	❑ Orthopedic	____	❑ TB contact	____
❑ Convulsions	____	❑ Poliomyelitis	____	❑ Hearing loss	____
❑ Diabetes	____	❑ Rheumatic Fever	____	❑ Vision loss	____
❑ Epilepsy	____	❑ Serious accident	____		

If this pupil has had any of the above conditions, did he/she receive medical care? ❑Yes ❑No
Is he/she under treatment now? ❑Yes ❑No

Please check any of the following signs and syptoms you have recently observed:

❑ Tires easily	❑ Frequent sore throats	❑ Nail biting
❑ Underweight	❑ Frequent nose bleeds	❑ Restlessness
❑ Overweight	❑ Earaches	❑ Shyness
❑ Frequent headaches	❑ Fainting	❑ Does not like school
❑ Frequent colds	❑ Frequent stomach aches	❑ Does not get along with others

Has the pupil consulted a physician about the above symptoms? ❑Yes ❑No
Has the pupil had a complete physical in the past year? ❑Yes ❑No
Is this pupil on any kind of medication? ❑Yes ❑No
If so, what? _____
For what condition? _____
Is this pupil under medical care at this time? ❑Yes ❑No
Name of doctor or clinic: _____
Futher comment: _____

Has the pupil ever attended a Houston ISD school? _____
Name of School Date Attended

PLEASE FEEL FREE TO CONSULT WITH THE SCHOOL STAFF ABOUT HEALTH PROBLEMS.

_____
Signature Date

REVISED 11/03