Cassville R-IV School District
Student Health Inventory

Health Areas (Mark all that apply)	Description
Date: / /	
Student Last Name:	
Student First Name:	Middle Name:
Gender:	☐ Male ☐ Female
Grade:	Birth Date: / /
Name of Previous School:	City: State:
☐ Allergies	Allergic to: Reaction: Needs Epi-Pen: ☐ Yes ☐ No
☐ Asthma	☐ Mild ☐ Severe Specify type and/or cause of asthma attack: Takes daily medication: ☐ Yes ☐ No If yes, specify: Takes emergency medication: ☐ Yes ☐ No If yes, specify:
☐ Bee Sting Allergy	Needs antihistamine tablet if stung: ☐ Yes ☐ No Needs Epi-Pen if stung: ☐ Yes ☐ No
☐ Dental Problems	Has received dental care? ☐ Yes ☐ No Date of last dental exam: / /
☐ Diabetes	Test blood routinely: ☐ Yes ☐ No Describe diet & insulin routine:
☐ Ear Infections	☐ Occasionally ☐ Frequently Is under care of physician? ☐ Yes ☐ No Date of last doctor's visit: / /
☐ Epilepsy or seizures	Takes daily medication? ☐ Yes ☐ No
☐ Heart Condition	Is under care of physician? ☐ Yes ☐ No Specify any restrictions at school:
☐ Orthopedic Problem	Is under care of physician? ☐ Yes ☐ No Specify any restrictions at school:
☐ Serious Injury now or in the past	Specify:
☐ Other illness (including ADD or ADHD) now or in the past	Specify: Takes daily medication? ☐ Yes ☐ No If yes, specify: Takes emergency medication: ☐ Yes ☐ No If yes, specify:
☐ Surgeries/Operations	Specify:
☐ Has health condition which prevents participation in regular PE	Specify problem and limitations:
☐ Other Health Problem	Specify problem and medications:
Parent Signature	Date: / /
Emergency Contact Names & Numbers:	( ) - ( ) -