

STUDENT HEALTH INVENTORY

Pacific Grove Unified School District
555 Sinex Avenue
Pacific Grove, CA 93950

Date _____
School Pacific Grove Middle
Grade _____

TO BE COMPLETED BY PARENT OR GUARDIAN

1. STUDENT'S NAME _____ SEX ____ BIRTHDATE _____
ADDRESS _____ PHONE NO. _____
NAME/LOCATION OF LAST SCHOOL ATTENDED _____

2. Medical history (check the ones that apply to your child)

- | | | |
|--|---|---|
| <input type="checkbox"/> Orthopedic Problems | <input type="checkbox"/> Tires Easily | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Measles (3 day) Rubella |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Frequent Stomach Aches | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Measles (10 day) Rubeola |
| <input type="checkbox"/> Many Colds | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hepatitis | _____ |

_____ Allergy (if so, to what? Insect stings, foods, etc.) _____
Doctor's recommendations _____
Other illnesses, operations, injuries and age of occurrence: _____

3. EXAMINATIONS: (Please give dates)

Last physical examination _____ Doctor's name _____
Tuberculin Skin Test: Date _____ Results _____
Is your child under a doctor's care now? ____ Yes ____ No
Is your child taking a medication regularly? ____ Yes ____ No
If yes, name of medication and dosage _____
Reason for medication _____

Does your child receive regular dental care? ____ Yes ____ No
Name of dentist _____

Has your child ever been examined by an eye doctor? ____ Yes ____ No
If yes, give date of last examination _____ Doctor's name _____
Does your child wear glasses? _____ Contact lenses? _____

4. IF THERE IS ANY CHANGE IN THE CHILD'S HEALTH THAT AFFECTS HIS/HER ABILITY TO TAKE PHYSICAL EDUCATION, OR IF HE/SHE IS PLACED ON A REGULAR MEDICATION, (Educ. Code #12020) IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL. **PLEASE REQUEST FORMS AS NEEDED IF EITHER SITUATION EXISTS.**

Signature of Parent/Guardian Date