

School: _____
Grade: _____

Springfield Public Schools
STUDENT HEALTH INVENTORY

Student #: _____

Student's Name: _____ Date of Birth: _____ Sex: _____
Emergency Contact Name: _____ Phone Number: _____
Emergency Contact Name: _____ Phone Number: _____

Has student **previously** attended **another** Public School? No Yes → _____
Name of school OR previous program _____

For concerns, please circle "yes" or "no" and if yes, provide a comment:

CONCERN	YES	NO	COMMENTS	CONCERN	YES	NO	COMMENTS
ADD/ADHD	Y	N		Developmental Delay	Y	N	
Allergies (food, insects, latex, other)	Y	N		Diabetes	Y	N	
Allergies (environmental, seasonal, meds)	Y	N		Genetic Disorder	Y	N	
Assistive Devices	Y	N		Head Injury/Concussion/TBI/ABI	Y	N	
Asthma (history or under treatment)	Y	N		Hearing (aids/FM device)	Y	N	
Autism	Y	N		Heart (not innocent murmur)	Y	N	
Behavioral and/or Emotional	Y	N		Migraines	Y	N	
Bladder	Y	N		Neuromuscular (cerebral palsy, muscular dystrophy)	Y	N	
Bleeding	Y	N		Nutrition (feeding issues)	Y	N	
Bone or Joint Problems	Y	N		Seizures (history of or under treatment)	Y	N	
Bowel	Y	N		Sickle Cell Disease or Trait	Y	N	
Cancer (history or under treatment)	Y	N		Speech	Y	N	
Cystic Fibrosis	Y	N		Surgeries: (please list)	Y	N	
Dental	Y	N		Vision (glasses/contacts/blind)	Y	N	

Additional information regarding your child's health: _____

Does your child take medication (prescription or over-the-counter) for any of the above concerns?
 No Yes → (Name of medication(s)/reason for taking) _____

***Medication to be taken at school requires additional forms. Contact school nurse for policy guidelines.

Does your child require any special procedures? (catheterization, ostomy care, suctioning, tube feeding, diapering, etc?)
 No Yes → (describe) _____

Provider	Name	Approx. date of last visit
Pediatrician/Primary Care Provider	_____	_____
Specialist	_____	_____
Specialist	_____	_____
Hospital Preference	_____	_____
Dentist/Orthodontist	_____	_____
Outside Counseling; PT; OT; or Speech	_____	_____
Case Worker (if applicable)	_____	Phone Number _____

Health Insurance None Private Health Insurance Medicaid (MoHealthNet) → _____

SPECIAL EDUCATION or SERVICES student receives: IEP 504 Dietary 504 Modified PE PT OT
Number _____

Transportation to/from school: Walk Car Bus (# _____) Daycare (_____) _____
Name of daycare/program _____

I understand if my child is injured or becomes seriously ill and the school nurse, principal or designee cannot notify me by telephone, they will secure medical attention for my child and use ambulance services if necessary. I also understand that I will be responsible for the costs of such medical services and care.

Signature of legal parent/guardian _____ Relationship _____ Date _____