



Cudddeback

“National Blue Ribbon Award Winner 1994”
“California Distinguished School Award Winner 1993”

UNION SCHOOL DISTRICT

P.O. Box 7 • 300 Wilder Road • Carlotta, California 95528 • (707) 768-3372 • FAX 768-3211

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Please fill out this Health Inventory for each student. It will assist the HCOE nursing staff to better monitor the health needs of our students.

Thank you for your cooperation!

The HCOE HEALTH TEAM

ANNUAL HEALTH INVENTORY

STUDENT NAME: _____ GRADE: _____ DATE OF BIRTH: _____

HEALTH PROBLEMS Please check all that apply.

- Asthma Rescue inhaler? Yes No At school? Yes No Hospitalization? Yes No Last date _____
- Seizure disorder/epilepsy Type and description of seizure: _____ Date of last seizure: _____
- Diabetes Type 1 Type 2 Managed by: Diet only Oral meds Insulin injection Insulin pump
- History of heart problem Describe: _____
- History of hospitalization/surgery Describe/date: _____
- Known vision loss Right Left Describe: _____
- Wears contact lenses/glasses **Please check one:** For reading only For distance only At all times
- Known hearing loss Right Left Describe: _____
- Wears hearing aide Right Left Describe: _____
- Other medical condition(s)** or other/further details on conditions above: _____

Restrictions on physical activity: _____

Other medical restrictions: _____

Allergies (including bee sting reactions, etc.) List specific item(s) student is allergic to: _____
Describe allergic reaction and treatment: _____

Is Epi-Pen prescribed? Yes No Will Epi-Pen be available at school? Yes No

CURRENT MEDICATION(S) Circle one: Yes No (If medication taken during school hours, please complete a Consent of Medication form.)
If yes, name of medication(s) Dosage Time taken Purpose

Parent/Guardian Signature: _____ Date: _____