Uncompahgre Board of Cooperative Services
Student Health Inventory

Year 2018/19 Grade_____ School Telluride Public School

To assist in providing health services at school, please complete the following and return to the school. Please call Christine Tschinkel at 369-7103 with any questions or concerns.

(circle one)

Student Name _____ Birthdate _____ M F
Last First Middle

Does student have private health insurance? Yes No Medicaid? Yes No
If your child is covered under Medicaid, do we have permission to bill for health related services? Yes No
ID#_____
CHIP_____

If your child does not have health insurance, do you grant the school district Nurse permission to share this information with Medicaid/CHP+ enrollment counselor? Yes No

Name of parent or guardian _____ Daytime phone _____

Doctor's name _____ Date of last physical _____

Dentist's name _____ Date of last exam _____

Is student under an orthodontist's care Yes No Doctor's name _____

Does student have any of the following?

Allergies Yes No To drugs, food, insects, pollen? Please list_____
Has the allergy required emergency action in the past? Yes No
If yes, was an Epinephrine pen prescribed? Yes No
If yes, can student administer injection on his/her own? Yes No
Comments _____

Bee Sting Yes No Describe reactions _____
Difficulty breathing? Yes No Need emergency medication? Yes No

Asthma Yes No Triggered by? _____ Medication or treatment_____
Diagnosed by doctor_____ Date ___Date of last episode__
Does student require medication to be given at school? Yes No
Grades 7-12 can self carry their inhaler after a self carry form is filled out and given to the Nurse. A back up inhaler for the Nurse's office is recommended.

Diabetes Yes No Takes Insulin? Yes No Date diagnosed _____
Does student require medication to be given at school? Yes No
Does student know how to use own medication? Yes No

Epilepsy/ Seizures Yes No Describe seizure_____
Date of last seizure_____ Medication_____
Is student currently under doctor care for seizures? Yes No
Does student require medication to be given at school? Yes No

Tuberculosis Yes No Diagnosed by doctor_____ Date_____

Speech Problems Yes No Describe_____

Heart condition Yes No Describe_____
List physical restrictions _____

OVER

Bone/Joint problems or arthritis Yes No Describe_____
List physical restrictions _____

Chicken Pox Yes No Date of contraction_____

Check all the following regarding health concerns that pertain to student:

Eyes:
Date last seen by eye doctor _____
__ Glasses __ Contacts
Date of last prescription _____
__ reading
__ distance
__ contacts
__ difficulty seeing
__ lazy eye
__ concerns _____

Ears:
__ known hearing loss
__ frequent infections
__ tubes
__ hearing difficulties, explain:
_____
_____
_____

Hearing Aids:
__ right
__ left
__ wear at school
__ other
__ concerns_____
_____
_____

Other:
__ menstruation
__ blood disorder
__ blood pressure
__ nosebleeds
__ eating
__ sleeping
__ bladder
__ requires catheterization
__ lungs
__ neurological
__ headaches
__ bowel
__ requires diapering
__ phobias
__ ADD/ADHD
__ head Injury
__ dental
__ bedwetting
__ skin
__ other_____
__ other_____

Medication:

Is student taking daily medication at home? Yes No At school? Yes No Emergency Only? Yes No
Name of medication and reasons for taking:
_____
_____

If student requires medication at school, please obtain the appropriate form found in the school office.

List serious illness or injuries_____

List any operations_____ Conditions that prevent PE participation?
Explain: _____

If student requires a change in PE participation, please obtain the appropriate form found in the school office.

Check services student currently receives:
__ Special Education services (i.e., resource room)
__ Speech/Language __ OT/PT services __ Counselor __ Title I __ Special diet
__ requires special health care, please explain:
_____
_____

Do you give us permission to input your child's vaccine record into CIIS-Colorado Immunization Information System
Please circle -Yes or No
Any other health concerns:
_____
_____
_____

_____ _____
Signature of legal parent/guardian Date