WEST VALLEY SCHOOL DISTRICT #363
ANNUAL HEALTH INVENTORY

RESET FORM

STUDENT NAME: _____ **DATE OF BIRTH**_____

SCHOOL: _____ **GRADE**_____

DOES YOUR CHILD HAVE A LIFE-THREATENING HEALTH CONDITION (Do not leave blank)? YES ☐ NO ☐

IF YES, THE SCHOOL REQUIRES A MEDICATION/TREATMENT ORDER AND A MEETING WITH THE NURSE BEFORE YOUR CHILD CAN ATTEND SCHOOL.
Nurses will communicate with prescriber, when necessary, to confirm or clarity orders as needed.

Please check your child's current and past health concerns. Please briefly describe the concern. If the concern is in the past, please indicate the date.

☐ **Allergy**
- ☐ **Food**/Nuts_____ Severe ☐ Mild ☐
  Type of reaction_____Treatment_____EpiPen ☐
- ☐ **Bee Sting**_____ Severe ☐ Mild ☐
  Type of reaction_____Treatment_____EpiPen ☐
- ☐ **Drug**_____ Severe ☐ Mild ☐
  Type of reaction_____Treatment_____

☐ Asthma_____ Inhaler at school? Yes ☐ No ☐
☐ ADD/ADHD _____Medication required during school day? Yes ☐ No ☐
☐ Diabetes _____ Type 1 ☐ Type 2 ☐
☐ Seizures _____
☐ Heart Conditions _____
☐ Stomach /Intestinal Conditions_____
☐ Kidney/Bladder Conditions_____
☐ Hearing Problem _____
☐ Chronic Ear Infections_____
☐ Vision Problem/Glasses_____
☐ Orthopedic Conditions _____
☐ Mental Health Concerns _____
☐ Serious Accident/Injury _____
☐ Other _____

Has your child had previous surgery/hospitalization? Yes ☐ No ☐
If yes, please specify: _____

Does your child require medication on a regular basis (***at home***) Yes ☐ No ☐ (***at school)*** Yes ☐ No ☐
If yes, please specify: _____

I give permission for this information to be released to school personnel on a need-to-know basis for the health and safety of my child.

_____ _____
Parent Signature Date

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