Olympia Christian School
Journey to Excellence

(360) 352-1831

HEALTH INVENTORY

Page 1-To be filled out by ***PARENT/GUARDIAN***

(Prior to examination by physician)

1) Name of student_____ Age_____
Address_____ Birth date _____/_____/_____
Home Phone_____
Father's Name_____ Cell phone_____
Mother's name_____ Cell phone_____

Whom to notify in case of illness (give name, address, phone numbers)
A)_____ B)_____
_____ _____
_____ _____

Does student live at home with parents? Mother___ Father___ Other_____

Does student have coverage by accident or hospitalization policy? (state type) _____

2) Past Illnesses (please check those student has had)

Measles____	Scarlet fever____	Heart disease____	Whooping cough_____
Diphtheria_____	Polio_____	Chickenpox_____	
Epilepsy____	Diabetes____	Rheumatic fever____	Frequent colds_____

Hay fever or asthma_____

List any other serious illnesses, operations, or injuries, and age when occurred:
_____
_____
_____

3) Has the student ever been around anyone known to have tuberculosis? Yes__ No__
Has he/she ever been skin tested for tuberculosis? Yes__ Year_____ No__
Has he/she ever had a chest X-ray? Yes__ Year_____ No__

4) When did the child last see the dentist? Date_____
(recommend visit twice yearly)

5) Has the student had his eyes examined? Date_____ By whom?_____

6) Comment on student's habits: How many hours sleep does he usually get?_____
Does he participate in outdoor activities? Not at all_____ Moderately_____ Continuously_____
Does he prefer reading or watching TV to the above? Yes___ No___
Eating habits: Eats only at meals____
In between meals occasionally____
Frequently____

7) List any other items helpful to the school program in planning for student's health:_____
_____

Signature of Parent/ Guardian:_____ Date:_____

MEDICAL EVALUATION OF STUDENT

Page 2 - To be filled out ***BY THE PHYSICIAN***

The following information is requested so that the school and parent/guardian can work together to meet the physical, intellectual, and emotional needs of the child according to the physicians recommendations. A physical examination or a health certificate from the family doctor shall be required of all students entering K or 1st and again at 9th grade for secondary students or when a child enters formal schooling for the first time. A completed form is mandatory for these particular grades, but may be requested by the school at any time for any grade if the student's file is lacking a signed doctor's certificate.

Student's Name_____ **Birth date**____/____/_____ **Sex**_____
MM DD YYYY

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1) A. Is the student subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other? Yes__ No__ Explain:_____

B. Does student have any other medical problem with which the school should be concerned? Yes__ No__
Explain:_____

2) A. Immunization as required by law. It is expected that the physician will administer whatever inoculations are indicated at the time of this examination. **Please include a complete updated immunization record.**

B. When was the last Tuberculin Test given to the student? Type_____ Date_____ Result _____

C. Is there evident need for dental care? Yes __ No__ Explain:_____

D. Is there a hearing defect for which the school could help compensate by seating or other action? Yes__ No__
Explain:_____

E. i) Has the student had a vision screening test? Yes__ No__ Result:_____

ii) Are there ocular defects that indicate need for referral to an eye doctor? Yes__ No__
Explain:_____

iii) Are there any visual defects for which the school could help compensate by seating or other action?
Yes__ No__ Explain: _____

3) Have there been any illnesses, accidents, operation, or congenital defects that limit the student's participation in:
Classroom activities? Yes__ No__ Physical education activities? Yes__ No__
Swimming? Yes__ No__
If so, explain:_____

4) Is there any mental, emotional, or physical condition, for which the student should remain under your periodic observation? Yes__ No__ If so, explain:_____
At what interval does the student need rechecks?_____

5) Physician's recommendation to school: _____
_____
_____

I would like the nurse_____ teacher_____ to contact me regarding this student._____

Doctor's Name:_____

Doctor's Signature_____**Date of examination:** _____/_____/_____

Office Name & Address:_____**Telephone #** _____