

Indiana Conference of Seventh-day Adventists®

PO Box 5000 Westfield IN 46074-5000 E-mail: education@indysda.org Phone: 317-844-6201 Fax: 317-571-9281 Website: www.indysda.org

Health Inventory

PERSONAL INFORMATION

Stu	dent's Full Legal Name	e						
Dat	e of Birth		Age	Telephone				
Add	dress							
Fat	her's Name		Mother's Name					
Whom to notify in case of illness (give address and phone numbers)								
(A)			(B)					
Doe	es the student live at ho	me with narents?	¬ Mother	r □ Other				
Does the student live at home with parents? Mother Father Other								
Does the student have coverage by accident or hospitalization policy? (state type)								
MEDICAL INFORMATION								
1.	Current or Previous II	Inesses (check all that app	ly):					
	□ Measles	□ Mumps	□ Rubella	□ Hepatitis	□ Scarlett Fever			
	☐ Heart Disease	□ Whooping Cough	□ Diphtheria	□ Chorea	□ Polio			
	□ Chickenpox	☐ Epilepsy	□ Rheumatic Fever	□ Diabetes	☐ Allergies			
	□ Asthma	□ HIV	☐ Frequent Colds	□ Other:				
List	List any other serious illnesses, operations, or injures, and age when occurred:							
		esse, specialisms, si mjeres	,					
2.		been around anyone known		☐ Yes	□ No			
		skin tested for tuberculosis		Year	□No			
	Has he/she ever had a	chest X-ray? ☐ Yes	S Year	□ No				

Page **1** of **2** Revised 08/14/2014

3.	When did the student last visit the dentist? (Recommended visit twice yearly)	Date				
4.	Has the student had his/her eyes examined?	Date	By whom?			
5.	Please list any allergies or reactions (i.e., food, insect stings, or medications, etc.):					
6.	Please list all medications the student is taking:					

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

Page **2** of **2** Revised 08/14/2014