Burrillville School System
Student Health Inventory

Grade: _____ Teacher: _____Homeroom: _____

Name: _____ Date of Birth: _____Tel.# _____

Address: _____ Town: _____ Zip: _____

Resides with: ____ Mother____Father_____Both_____Stepmother____Stepfather_____Other_____

Father's Name (Guardian): _____Work Tel.# _____

Mother's Name(Guardian):_____Work Tel.# _____

Name of Family Doctor: _____Tel.# _____

Brothers & Sisters: _____(M) _____(F) _____Age _____Grade_____
_____(M) _____(F) _____Age _____ Grade _____
_____(M) _____(F) _____Age _____ Grade _____

Does student have any know medical conditions? Yes____ No _____If yes, please explain:
_____
Does student take any medications? Yes____ No ____ If yes, what medication? _____
What dosage? _____ How often? _____ For what condition? _____
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Please fill in the year your child has had any of the following diseases or medical conditions

Allergies	____	Hearing	____	Pneumonia	____
Asthma	____	Heart	____	Rheumatic Fever	____
Chicken Pox	____	Hepatitis	____	Scarlet Fever	____
Convulsions	____	Kidney Disease	___	Tuberculosis	____ Active Yes ____ No ____
Diabetes	____	Measles	____	Visual Defect	____ Glasses: Yes ____ No ____
Epilepsy	____	Mumps	____		

Other: _____
Please list known current allergies : _____
Allergy Reaction: What happens when exposed? _____
_____
Has student had any accidents or injuries?
_____ Date: _____ Type: _____
Recent Operations: _____ Date: _____ Type: _____

Is student undergoing medical treatment at this time? If yes, reason: _____
_____

Child's physician: _____ Tel. # _____
May your child participate in a dental exam at school? Yes _____ No _____

To facilitate continuity of medical care while in the school setting, I give permission for any pertinent medical information to be shared with appropriate school faculty.

Parent/Guardian Signature: _____ Date:_____