ONTARIO-MONTCLAIR SCHOOL DISTRICT
HEALTH SERVICES
HEALTH INVENTORY

DATE _____

Last	First	☐M ☐F Gender	Date of Birth	Place of Birth

Address	City, State	Phone

Last School Attended	City, State	Previous Ontario-Montclair District School Attended

Name of family physician or health plan _____ Birth weight _____

Child lives with ☐ Father ☐ Mother ☐ Stepmother ☐ Stepfather ☐ Foster Parent ☐ Grandparent

_____ _____

ILLNESS

	Yes	No
Chickenpox	☐	☐
German Measles (3 days)	☐	☐
Red Measles (10 days)	☐	☐
Scarlet Fever	☐	☐
Earache	☐	☐

MEDICAL/HEALTH PROBLEMS

(If yes, please explain below)

Vision	☐	☐
Wears glasses	☐	☐
Dental	☐	☐
Hearing	☐	☐
Uses hearing aids	☐	☐
Heart	☐	☐
Lungs	☐	☐
Kidney/Bladder	☐	☐
Bone/Joint	☐	☐

ALLERGIC/CHRONIC DISEASES

	Yes	No
Allergic reaction to insect sting	☐	☐
SEVERE _____ Mild _____		
Any other allergies	☐	☐
If so, please explain _____		
List all medications for allergies _____		
Asthma	☐	☐
Diabetes	☐	☐
Seizures	☐	☐
Epilepsy	☐	☐
If yes to any of the above, please explain _____		

LIST BELOW THE YEAR ANY OF THESE OCCURRED

Serious injuries/illnesses/accidents? (Explain and list dates) _____

Any surgeries? (Explain and list dates)