LEGACY ACADEMY
STUDENT HEALTH INVENTORY

Student's Name: __________________________ Date of Birth: ___________ Grade: _______

Parents/Guardians

Name: _________________________ Relationship: _______________ Phone: ____________

Name: _________________________ Relationship: _______________ Phone: ____________

Family Doctor: ____ Phone: ____________________

Physician's Nurse: _____________________________________ Phone: ____________________

Does Your Child Have

Food Allergies: Yes / No Please list: ____
Describe reaction: ____
____
Has the allergy required emergency action in the past? Yes / No

Bee Sting Allery: Yes / No Describe reaction: ____
____
Any difficulty breathing? Yes / No
Emergency medication needed? Yes / No

Asthma: Yes / No Triggered by: ____
Treatments: ____

Epilepsy/Seizure: Yes / No Describe seizure: ____
____
Date of last seizure: _________ Medication: ________________
Is student currently under a doctor's care for seizures? Yes / No

Diabetes: Yes / No Takes insulin? Yes / No Date diagnosed: ________________
____

Heart Condition Yes / No Describe: ____
____

Eyes/Vision Does the student wear glasses? Yes / No ____________________________

____

Ears/Hearing Frequent infections, tubes, hearing difficulty: _________________________

____

If your child has any additional special health considerations or they require special care please provide detailed information below.

____
____
____
____
____
____
____

Immunization History

Immunizations	DATES GIVEN				
	Dose #1	Dose #2	Dose #3	Dose #4	Dose #5
DPT/DT/aP/DT					
IPV (Polio)					
Hib					
MMR					
Hepatitis B					
Varicella (Chicken Pox)					
Pneumococcal					

* If there are any changes in your child's health conditions or you have any questions or concerns please contact the school office.