Student ID #_____

MARSHFIELD PUBLIC SCHOOLS
MARSHFIELD, MASSACHUSETTS 02050

STUDENT HEALTH INVENTORY

STUDENT NAME: _____ GENDER: M F
(Last Name / First Name / Middle Name / Circle One)

Date of Birth:_____ City/Town of Birth:_____ SS#:_____-_____-_____

Street Address:_____ Phone:_____

Mailing Address:_____ Zip Code:_____ Grade Entering:_____

Email Address: _____

Primary Language of Home: ENGLISH OTHER:

STUDENT'S HEALTH HISTORY:

Have there been frequent absences from school for health reasons? Y N

If yes, why:_____

Has student ever had the following: Circle Yes or No, if Yes, give age and/or date

Chicken Pox Y N _____
Convulsions Y N _____
Diabetes Y N _____
Diptheria Y N _____
Ear Infections Y N _____
Encephalitis Y N _____
Heart Disease Y N _____
Hernia Y N _____
Other Y N _____

Measles (German) Y N _____
Measles (reg.) Y N _____
Mumps Y N _____
Meningitis Y N _____
Poliomyelitis Y N _____
Scarlet Fever Y N _____
Whooping Cough Y N _____
Kidney Disease Y N _____

Physical Handicaps: Y N If yes, explain: _____

Asthma Y N _____ Allergies Y N _____
Operations or serious accidents? Y N _____
Dizzy spells, fainting, blackouts? Y N _____
Hearing Loss Y N _____ Hearing Aid Y N _____
Speech Problem Y N _____ Vision Problem Y N _____
Glasses Y N _____ Special Seating Y N _____
Is daily medication required Y N If yes, what kind? _____
Why and when taken? _____
Contact with tuberculosis Y N _____ Date of last x-ray _____
Do you believe the student is able to take the regular physical education program? Y N
If not, why? _____
Last Medical Exam Date: _____ By whom? _____

SIGNATURE: _____ DATE: _____
Print Name: _____