Springfield Public Schools

KHS Student Health Inventory **School Year 2025-2026** **Student #**_____

Student	School	Grade/Teacher
Address	Birth Date	Gender

Parent/Guardian/Emergency Contact	Relationship	Phones	
		Cell:	Work:
		Cell:	Work:
		Cell:	Work:

INDICATE IF STUDENT HAS BEEN **DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

Allergy to Insect Stings	▁	▁	Rate the reaction: ▁mild ▁moderate ▁life-threatening Does your child require an EpiPen? ▁yes ▁no
Allergies (other)	▁	▁	List: Does your child require an EpiPen? ▁yes ▁no
Food Allergies	▁	▁	Food(s): ▁ peanut ▁dairy ▁eggs ▁other (list) Does your child require an EpiPen? ▁yes ▁no
Medication Allergies	▁	▁	List:
Asthma (guardian to provide Asthma Action Plan)	▁	▁	Rate the severity: ▁mild ▁moderate ▁ life-threatening Asthma medication taken at home: Asthma medication required at school:
ADD/ADHD	▁	▁	Medication for ADD/ADHD: Date of Diagnosis By Whom:
Autoimmune Disorder	▁	▁	Specify:
Blood Disorder (sickle cell, Hemophilia)	▁	▁	Specify: Treatment:
Bone/Muscle Problems	▁	▁	Specify: Activity Restrictions:
Bowel/Bladder Issues	▁	▁	Specify:
Cancer	▁	▁	Specify: Treatment:
Cystic Fibrosis	▁	▁	Treatment:
Diabetes	▁	▁	▁Type 1 Insulin Dependent Dr. Name: ▁Type 2 Diabetes
Genetic Disorder/Developmental/Autism	▁	▁	Specify:
Heart Condition	▁	▁	Specify: Restrictions:
Migraine Headaches	▁	▁	Triggers: Treatment:
Neurological Disorder (CP,MD)	▁	▁	Specify:
Seizure Disorder	▁	▁	Type of Seizure: Medications:
Mental Health Behavioral Issues	▁	▁	Specify: Date of Diagnosis: Treatment/Medication: By Whom:
Visually Impaired/Blind	▁	▁	Specify: Treatment:
Hearing Loss	▁	▁	▁Hearing Loss Right Ear ▁Hearing Loss Left Ear ▁Hearing Aid(s)
Surgeries	▁	▁	Specify: Date(s):
Other Serious Illness/Injury	▁	▁	Specify: Date of Onset/Accident:

Health Condition Yes No Explanation if "Yes"

**I understand if my child is injured or becomes seriously ill and the school nurse, Principal or designee cannot notify me by phone, they will secure medical attention for my child and use ambulance services if necessary. I also understand that I will be responsible for the

costs of such medical services and care.

Parent/Guardian Signature: _____ Printed Name: _____Date:_____

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