Indiana Conference of Seventh-day Adventists®
PO Box 5000
Westfield IN 46074-5000
E-mail: education@indysda.org
Phone: 317-844-6201
Fax: 317-571-9281
Website: www.indysda.org

Health Inventory

PERSONAL INFORMATION

Student's Full Legal Name _____

Date of Birth _____ Age _____ Telephone _____

Address _____

Father's Name _____ Mother's Name _____

Whom to notify in case of illness (give address and phone numbers) _____

(A) _____ (B) _____

_____ _____

_____ _____

Does the student live at home with parents? ☐ Mother ☐ Father ☐ Other _____

Does the student have coverage by accident or hospitalization policy? (state type) _____

MEDICAL INFORMATION

1. Current or Previous Illnesses (check all that apply):

☐ Measles	☐ Mumps	☐ Rubella	☐ Hepatitis	☐ Scarlett Fever
☐ Heart Disease	☐ Whooping Cough	☐ Diphtheria	☐ Chorea	☐ Polio
☐ Chickenpox	☐ Epilepsy	☐ Rheumatic Fever	☐ Diabetes	☐ Allergies
☐ Asthma	☐ HIV	☐ Frequent Colds	☐ Other: _____	

List any other serious illnesses, operations, or injures, and age when occurred:

2. Has this student ever been around anyone known to have tuberculosis? ☐ Yes ☐ No
   Has he/she ever been skin tested for tuberculosis? ☐ Yes Year _____ ☐ No
   Has he/she ever had a chest X-ray? ☐ Yes Year _____ ☐ No

Revised 08/14/2014

3. When did the student last visit the dentist? (Recommended visit twice yearly) Date _____

4. Has the student had his/her eyes examined? Date _____ By whom? _____

5. Please list any allergies or reactions (i.e., food, insect stings, or medications, etc.):

6. Please list all medications the student is taking:

7. List any other items helpful to the school program in planning for student's health: