Health Inventory Summary

Teacher: Please list and check for each student who answered "yes" to any of the Health Conditions questions or had any other significant information on the Student Health Inventory. Use the "other" column for additional information that is on the form. Use additional forms if needed.

School _____ Teacher _____ Week of attendance _____

Student Name	Taking Meds	1 Asthma/Inhaler	2 Sting/bite	4 Med allergy	5 Food allergy	7 ADD/ADHD	8 Diabetes	9 Epilepsy/seizures	10 Chronic illness	11 Depression	12 Hearing	13 Vision	15 Eating	16 Recnet illness/exp	19 Sleepwalking	21 First time	Dietary restriction	Activity restriction	No Photo	Custody	Birthday	Other

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