

HEALTH INVENTORY

(To be filled in by parent, before examination by physician)

1. Name of student _____ Age _____ Date of Birth _____		
Address _____ Telephone _____		
Father's name _____		Mother's Name _____
Whom to notify in case of illness (give addresses and phone numbers) _____		
(A) _____		(B) _____
Does student live at home with parents? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____		
Does student have coverage by accident or hospitalization policy? (state type) _____		
2. Past illnesses (please check those student has had)		
_____ Measles	_____ Scarlet Fever	_____ Heart Disease
_____ Whooping Cough	_____ Diphtheria	_____ Chorea (St. Vitus' Dance)
_____ Polio	_____ Chickenpox	_____ Epilepsy
_____ Rheumatic Fever	_____ Diabetes	_____ Hay Fever or Asthma
List any other serious illnesses, operations, or injuries, and age when occurred:		
3. Has this student ever been around anyone known to have tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has he/she ever been skin tested for tuberculosis? <input type="checkbox"/> Yes Year _____ <input type="checkbox"/> No		
Has he/she ever had a chest X-ray? <input type="checkbox"/> Yes Year _____ <input type="checkbox"/> No		
4. When did the child last visit the dentist? Date _____		
(Recommend visit twice yearly)		
5. Has the student had his eyes examined? Date _____ By whom? _____		
6. Please list any allergies or reactions (i.e., food, insect stings, or medications, etc.): _____		

Please list any medications child is taking: _____		

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

2007-2008 School Year
 Indiana State Department of Health
 School Immunization Requirements & Recommendations
 Quick Reference Guide

	3-5 year olds	K	1	2	3	4	5	6	7	8	9	10	11	12
DTaP/DTP/DT/Td	4	5	5	3	3	3	3	3	3	3	3	3	3	3
Polio **	3	4	4	4	4	4	4	4	4	4	4	4	4	4
Measles	1	2	2	2	2	2	2	2	2	2	2	2	2	2
Mumps	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Rubella	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Hepatitis B ***	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Varicella ~	1	1	1	1	1	1	1	1	1	1	1	1	1	1

* Four doses of DTaP/DTP/DT are acceptable if the fourth dose was administered on or after the child's fourth birthday.

** If any combination of IPV or OPV was used 4 doses are required by 4-6 years of age regardless of age when administered. Four doses of all IPV or OPV are a complete series OR three doses of all OPV or all IPV are acceptable if the third dose was administered on or after the child's fourth birthday.

*** The 2-dose alternative adolescent Hepatitis B vaccine schedule (using Recombivax HB in 11-15 year olds) is acceptable if properly documented.

~ Parental written report of a child's history of chickenpox is acceptable as proof of immunity (no vaccine needed). A written statement from the parent/guardian indicating dates of disease and signed is all the documentation needed. Documentation by a physician is not necessary.

Schools are required to report vaccination coverage rates for kindergarten, first grade, and sixth grade by November 1st, 2007.

Education material to be distributed:

Meningococcal Disease – All grades.

Human Papillomavirus (HPV) Infection – 6th grade girls

Hepatitis B Vaccine – 12th grade all