Boulder Elementary School

Cumulative Health Record

Today's Date: _____

Student Name: _____

DOB: _____

Does your child have any of the following:

Asthma	○Y○N	Medications:
Allergies	○Y○N	Specify:
ADD/ADHD	○Y○N	Medications:
Congenital Defects	○Y○N	Specify:
Chronic Conditions	○Y○N	Specify:
Diabetes	○Y○N	Age of onset:
Heart Condition	○Y○N	Specify restrictions:
Seizures	○Y○N	Age of onset: Medications:

****If you answered yes to any of these, you will need to consult with our nurse to fill out an Action Plan****

Does your child have:

Vision problems ○Y○N Contacts or glasses ○Y○N

Hearing problems ○Y○N Hearing aids ○Y○N Frequent ear infections ○Y○N

Physical restrictions or health problems that may require special seating, bathroom privileges, etc. ○Y○N

If yes, please specify:

Special diet or food restrictions ○Y○N If yes, please specify:

Has your child ever had:

Surgery ○Y○N If yes, please specify:

Serious Injuries ○Y○N If yes, please specify:

Chicken Pox ○Y○N Date: _____

Is your child currently taking any medications? ○Y○N

Name of medication(s):

For Use by School Personnel

Year														
Grade														
HT	Fall													
	Spring													
WT	Fall													
	Spring													
Vision	Corrective Lenses?													
	Right Eye													
	Left Eye													
	Both Eyes													
	Near Point													
	Muscle Balance													
	Color (Check once by 7th Grade)													
Hearing	Pure Tone Right Ear													
	Pure Tone Left Ear													
	Impedance													
Dental	Teeth Condition, Class I, II, III													
	Fluoride Mouth Rinse													
Scoliosis Screening														
Other , Specify														

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Date	Nurses Notes