

# Walnut Valley Unified School District

"KIDS FIRST - Every Student, Every Day"

880 S. Lemon Avenue • Walnut, California 91789 • Tel. (909) 595-1261

## STUDENT HEALTH ASSESSMENT

Your child's learning depends upon good health. Please complete the assessment if your child has health problems. If your child has **NO HEALTH PROBLEMS**, fill out the student information, sign and date the form on the bottom and check the box indicating "**NONE**" below your signature. Current health problems/conditions should also be listed on the student's emergency card.

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_  
*Last First Middle*

Parent/Guardian Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_-\_\_\_\_

**If no health problems, proceed to signature.**

### Does your child have:

Allergies  Yes  No To drugs, food, pollen? Please list \_\_\_\_\_  
Has the allergy required emergency (911) action in the past?  Yes  No  
Comments: \_\_\_\_\_

Bee sting allergy  Yes  No Describe reaction \_\_\_\_\_  
Difficulty breathing?  Yes  No  
Need emergency medication (911)  Yes  No

Asthma  Yes  No Triggered by \_\_\_\_\_ Treatment \_\_\_\_\_  
Diagnosed by doctor \_\_\_\_\_ Date \_\_\_\_\_

Diabetes  Yes  No Takes insulin?  Yes  No Date Diagnosed \_\_\_\_\_  
Endocrinologist \_\_\_\_\_ Phone \_\_\_\_\_

Epilepsy/Seizures  Yes  No Describe seizure \_\_\_\_\_  
Date of last seizure \_\_\_\_\_ Medication \_\_\_\_\_  
Is student currently under a doctor's care for seizures?  Yes  No  
Neurologist Name \_\_\_\_\_ Phone \_\_\_\_\_

Heart Condition  Yes  No Describe \_\_\_\_\_  
Any physical restrictions? \_\_\_\_\_ Medication  Yes  No  
Cardiologist name \_\_\_\_\_ Phone \_\_\_\_\_

Bone or joint problems  Yes  No Describe \_\_\_\_\_  
List physical restrictions/limitations \_\_\_\_\_

### Select the following regarding health concerns that required medical attention:

Hearing Loss  Yes  No Explain \_\_\_\_\_ Hearing aid  Yes  No

Nosebleeds  Eating disorder  Sleeping  Bladder  Requires catheterization

Respiratory  Neurological  Headaches  Bowel  Requires diapering

Phobias  ADD/ADHD  Dental problems  Skin  Menstrual problems

Blood disorder  Blood pressure  Other \_\_\_\_\_

Does the student take daily medication(s) and reason for taking \_\_\_\_\_

List serious illness or injuries \_\_\_\_\_

Other health information or concerns \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

NONE