West Canada Valley School District
Health History Form

Students Name: _____DOB_____Grade_____

Resides with: _____ Phone: _____

Has your child ever/currently have:	**YES**	**NO**	**If Yes, please explain & provide dates**
Ongoing medication condition			
Sees a medical specialist			
Allergies			☐ Food ☐ Env't ☐ Meds ☐ Other
Been hospitalized			
Had an operation			
Miss 5+ days of school in a row b/c of illness or injury			
Passed out, Concussion, serious head injury			
Convulsions or Seizures			
Vision Problem/condition			☐ Glasses ☐ Contacts
Hearing Problem/condition			☐ Hearing aid ☐ Cochlear Implant
Dental condition: bridge, braces, mouthpiece, chipped tooth			
Have any family members under the age of 50 ever:	**YES**	**NO**	**If yes, please specify**
Had a heart attack or stroke			
Serious health problems			

CHECK ALL THAT APPLY TO YOUR CHILD

****(**If marked: please describe on back of this form & provide doctors note)****

__ADHD
__ASTHMA/TROUBLE BREATHING
__AUTISM/ASPERGER
__DENTAL INJURY
__FREQ. EAR INFECTIONS
__GI CONDITIONS (Ulcer, reflux, IBS)
__HEADACHES/MIGRAINES
__HEART CONDITION/BP
__DIABETES
__URINARY CONDTION
___SCOLIOSIS
___SINGLE ORGAN
___SKIN CONDITION
___SPEECH CONDITION
___OTHER

CURRENT MEDICATION	**YES**	**NO**	**PLEASE LIST NAME, DOSE, TIME(S)**
GIVEN AT SCHOOL			
TAKEN AT HOME			

Parent/Guardian Signature: _____Date:_____