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**