Wellsville Central School
Annual Student Health History Update

Student Name:	**DOB:**	**Gender:**
	Age:	**Date:**
Parent/Guardian: (Person completing this form)	Primary Phone:	
Grade: ☐PS ☐PK ☐K ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12		

Has your child ever:	**Yes**	**No**	**If yes, please explain and include date:**
Had a history of COVID positive			
Was your child hospitalized for COVID?			
Was your child symptomatic for COVID?			
Did you see a health care provider for their COVID symptoms?			
Had Multisystem Inflammatory Syndrome from COVID?			
Had Cardiac Symptoms from COVID?			
Had a serious illness			
Had frequent illnesses or infections			
Had an ongoing medical condition			
Seen a medical specialist			
Has allergies:			
Food:			Reaction:
Environmental:			Reaction:
Insect Bite:			Reaction:
Medication:			Reaction:
Latex			Reaction:
Other:			Reaction:
Has an Epipen Auto-Injector			For:
Been Hospitalized			
Had Surgery			
Had an injury requiring an ER visit			
Missed 5 days of school in a row due to illness/injury			
Had a bone/muscle injury			
Passed out, had a concussion, or serious head injury			
Had a convulsion/seizure			
Has/Had a vision problem or condition			☐glasses ☐contacts ☐protective eyewear
Has/Had a hearing problem or condition			☐hearing aid ☐cochlear implant
Wears a dental bridge, braces, or a mouthpiece			

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ADHD
☐Asthma/trouble breathing/shortness of breath
☐Autism / Asperger
☐Bleeding Disorder
☐Dental Injuries
☐Diabetes
☐Ear Infections
☐Eating Disorder
☐Stomach & GI Conditions (constipation, ulcer, reflux, IBS)
☐Headaches / migraines
☐Heart Conditions
☐Heart Murmur
☐High Blood Pressure
☐Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐Mononucleosis
☐Scoliosis
☐Seizure Disorder
☐Single Organ (kidney, testicle, eye)
☐Skin Condition
☐Urinary Condition
☐Other ________________________

Current Medications	**Yes**	**No**	**Please list name, dose, time(s), and prescribing doctor:**
Given at school			
Taken at home			
Assistive Equipment	**Yes**	**No**	**Please check all that apply:**
During or outside of school			☐crutches ☐walker ☐wheelchair ☐other
Treatments	**Yes**	**No**	**Please check all that apply:**
During or outside of school			☐insulin/blood glucose monitor ☐special diet ☐allergy awareness ☐inhaler/nebulizer/peak flow monitor

Is there any condition that would prevent your child from participating in physical education classes or sports?
☐No ☐Yes: ____

Please list any additional concerns: ____

Parent/Guardian Signature: ____ **Date:** ________________________