THE WOODHALL SCHOOL

ACADEMIC YEAR 2017 – 2018

STUDENT/ FAMILY HEALTH & MEDICAL HISTORY

HEALTH

STUDENT NAME _____ BIRTHDATE _____ / _____ / _____

Do you have or have you ever had ... ?	Y	N
Alcohol or other drug use		
Anemia/ blood disorder		
Asthma/ wheezing		
Back problems		
Cancer/ tumor		
Chest pain/ shortness of breath		
Dental problems		
Depression		
Diabetes		
Ear, nose, throat problems		
Eye problems		
Fainting/ loss of consciousness		
Fractures/ sprains/ dislocations		
Headaches/ migraines		
Head injury/ concussion		
Heart disease		
High blood pressure		
Intestinal/ digestive problems		
Kidney disease/ bladder infections		
Mononucleosis		
Pneumonia		
Recent weight change/ eating concerns		
Seizures		
Significant anxiety/ depression		
Sinusitis		
Skin problems		
Special diet		
Thyroid/ hormone problems		
Tobacco use		
Other illness		

If you answered YES to any of the above, please explain:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please use an additional sheet, if necessary.

BIRTH CITY_____ **HOSPITAL**_____

PERSONAL HISTORY

ALLERGIES

To medication: _____

_____

To food: _____

_____

Other: _____

_____

HOSPITALIZATIONS SURGERIES

Date	Description

MAJOR ILLNESS

Date	Description

DENTAL/ VISION INFORMATION

Eye/Vision Issues? ☐ Glasses ☐ Contact Lens ☐ No issues

Last eye examination _____

Dental Issues? ☐ Braces ☐ Bridge ☐ Plate ☐ Other:_____

FAMILY HISTORY (BIOLOGICAL)

Relationship	Age	State of Health	Medical Issues
Father			
Mother			
Siblings			

Unless all medical information is supplied, The Woodhall School is at a disadvantage in caring and seeking proper medical attention for the student named above.

I am aware of this and have completed the medical forms accurately and completely to the best of my knowledge.

_____

Signature of Parent/Guardian

_____

Date