OFFICE OF CATHOLIC SCHOOLS DIOCESE OF ARLINGTON
CONFIDENTIAL STUDENT HEALTH HISTORY UPDATE

PARENT/GUARDIAN: **Please complete this form at the beginning of each school year.**

Name _____ Sex: M F DOB: _____ School _____Grade _____

Mother / Guardian_____ Work #_____ Home #_____Cell #_____

Father / Guardian _____ Work #_____ Home #_____Cell# _____

Physician _____ Phone# _____ School Year _____

Complete the following checklist by indicating any of the following student conditions, past or present.

	YES*	NO	DATE
Allergies / Environmental			
Allergies / Food			
Allergies / Insect Stings or Bees			
Allergies / Latex			
Allergies / Medications			
Allergies / Other			
Asthma / Breathing Problem			
Behavioral Problem			
Bladder / Kidney Disorder			
Bleeding / Clotting Disorder			
Bone / Joint / Muscular Disorder			
Cancer			
Convulsions / Epilepsy / Seizure			
Dental Problem			
Developmental Problem			
Dizziness or Fainting			
Diabetes			
Dietary Restriction			
Digestive / Bowel Problem			
Eating Disorder			
Endocrine Disorder			
Head or Spinal Injury			
Headaches / Migraines			

	YES*	NO	DATE
Hearing Problem			
Heart Defect or Disease			
Hepatitis or Liver Problem			
Hernia			
Hypertension			
Immune System Disorder			
Infectious Disease, Current			
Infectious Disease, Inactive			
Lead Poisoning			
Menstrual Problem			
Mobility Limitation			
Mononucleosis			
Orthodontic Treatment			
Physical Education Restriction			
Psychological / Emotional Problem			
Scoliosis			
Skin Condition			
Soiling / Incontinence			
Speech Disorder			
Surgery or Hospitalization			
Tuberculosis			
Vision or Eye Disorder			
Other: (explain below)			

*****Provide details for all items above marked ***YES*** :_____

_____

Does the student's health condition require medically necessary medications or specialized health care treatments in school? ☐ YES ☐ NO Explain_____

_____

Does the student take any medications, homeopathic supplements, or nutritional & performance supplements? ☐ YES ☐ NO Explain. _____

_____

Specifically ***during or after exercise,*** has the student experienced any of the following? Check all that apply:

☐ Fainting / Passing-Out ☐ Heat Stroke ☐ *Severe* Lightheadedness / Dizziness ☐ Coughing / Wheezing ☐ Excessive Bruising

☐ *Extreme* Shortness of Breath ☐ Chest Pain ☐ Numbness / Tingling in_____ ☐ NONE APPLY

Was a Medical Evaluation done as a result of any of the above symptoms during exercise? ☐ YES ☐ NO Outcome:_____ _____

☐ **YES** ☐ **NO** **CONSENT FOR TREATMENT:** I give my permission for qualified school personnel to provide routine health care and first aid to my child as may be necessary during school and after school activities. I assume full responsibility for providing the school with all necessary student over-the-counter or prescription medications as well as necessary medical treatment supplies and authorizations.

☐ **YES** ☐ **NO** **CONSENT TO SHARE INFORMATION:** The school nurse and/or health aide have my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff, primary healthcare providers, and extended day, for use in meeting the educational and health needs of my student. This consent includes the sharing of personally identifiable health record information during immunization and communicable disease surveillance audits by the Virginia Department of Health and the Virginia Department of Social Services for licensed program compliance, if applicable.

Parent / Guardian Signature_____Date_____