

**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 _____ 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	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies / Food	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies / Insect Stings or Bees	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies / Latex	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies / Medications	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies / Other	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma / Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioral Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder / Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding / Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Bone / Joint / Muscular Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions / Epilepsy / Seizure	<input type="checkbox"/>	<input type="checkbox"/>	
Dental Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness or Fainting	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Dietary Restriction	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive / Bowel Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Head or Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	

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

*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 _____