Office of Catholic Schools excellence by design

Appendix F-1A

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*	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	◯	
COVID-19	◯	
Dental Problem	◯	
Developmental Problem	◯	
Dizziness or Fainting	◯	
Diabetes	◯	
Dietary Restriction	◯	
Digestive / Bowel Problem	◯	
Eating Disorder	◯	
Endocrine Disorder	◯	
Head or Spinal Injury	◯	
Headaches / Migraines	◯	

	YES*	DATE
Hearing Problem	◯	
Heart Defect or Disease	◯	
Hepatitis or Liver Problem	◯	
Hernia	◯	
Hypertension	◯	
Immune System Disorder	◯	
Infectious Disease, Current	◯	
Infectious Disease, Inactive	◯	
Lead Poisoning	◯	
Lyme disease/Tick Borne Illness	◯	
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*** : ____

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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 ____

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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________________

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