

**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 | | YES* | DATE |
|-----------------------------------|--------------------------|------|-----------------------------------|--------------------------|------|
| ADHD | <input type="checkbox"/> | | Headaches / Migraines | <input type="checkbox"/> | |
| Allergies / Environmental | <input type="checkbox"/> | | Hearing Problem | <input type="checkbox"/> | |
| Allergies / Food | <input type="checkbox"/> | | Heart Defect or Disease | <input type="checkbox"/> | |
| Allergies / Insect Stings or Bees | <input type="checkbox"/> | | Hepatitis or Liver Problem | <input type="checkbox"/> | |
| Allergies / Latex | <input type="checkbox"/> | | Hernia | <input type="checkbox"/> | |
| Allergies / Medications | <input type="checkbox"/> | | Hypertension | <input type="checkbox"/> | |
| Anxiety | <input type="checkbox"/> | | Immune System Disorder | <input type="checkbox"/> | |
| Asthma / Breathing Problem | <input type="checkbox"/> | | Infectious Disease, Current | <input type="checkbox"/> | |
| Autism | <input type="checkbox"/> | | Infectious Disease, Inactive | <input type="checkbox"/> | |
| Behavior Concerns | <input type="checkbox"/> | | Lead Poisoning | <input type="checkbox"/> | |
| Bladder / Kidney Disorder | <input type="checkbox"/> | | Menstrual Problem | <input type="checkbox"/> | |
| Bleeding / Clotting Disorder | <input type="checkbox"/> | | Mental Health Diagnosis | <input type="checkbox"/> | |
| Bone / Joint / Muscular Disorder | <input type="checkbox"/> | | Mobility Limitation | <input type="checkbox"/> | |
| Cancer | <input type="checkbox"/> | | Mononucleosis | <input type="checkbox"/> | |
| Convulsions / Epilepsy / Seizure | <input type="checkbox"/> | | Orthodontic Treatment | <input type="checkbox"/> | |
| COVID-19 | <input type="checkbox"/> | | Physical Education Restriction | <input type="checkbox"/> | |
| Depression | <input type="checkbox"/> | | Psychological / Emotional Problem | <input type="checkbox"/> | |
| Dental Problem | <input type="checkbox"/> | | Scoliosis | <input type="checkbox"/> | |
| Developmental Problem | <input type="checkbox"/> | | Skin Condition | <input type="checkbox"/> | |
| Dizziness or Fainting | <input type="checkbox"/> | | Soiling / Incontinence | <input type="checkbox"/> | |
| Diabetes | <input type="checkbox"/> | | Speech Disorder | <input type="checkbox"/> | |
| Dietary Restriction | <input type="checkbox"/> | | Surgery or Hospitalization | <input type="checkbox"/> | |
| Digestive / Bowel Problem | <input type="checkbox"/> | | Tuberculosis | <input type="checkbox"/> | |
| Eating Disorder | <input type="checkbox"/> | | Vision or Eye Disorder | <input type="checkbox"/> | |
| Endocrine Disorder | <input type="checkbox"/> | | Weight Concern (Under/Overweight) | <input type="checkbox"/> | |
| Head or Spinal Injury | <input type="checkbox"/> | | Other: (explain below) | <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: _____

I, _____ (parent/guardian name), give permission for identified 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, if needed during the school day. The school nurse and /or health aid have my permission to share my child's confidential health information, on a need-to-know basis, with appropriate members of the educational staff (e.g. teachers, counselors, athletic trainers, extended day staff), and healthcare team, for use in meeting the educational and health needs of my student.

By signing this document, I agree, acknowledge, and intend that my consent is valid on the date signed through the identified school year.

Parent / Guardian Signature _____ Date _____