

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			Headaches / Migraines		
Allergies / Environmental			Hearing Problem		
Allergies / Food			Heart Defect or Disease		
Allergies / Insect Stings or Bees			Hepatitis or Liver Problem		
Allergies / Latex			Hernia		
Allergies / Medications			Hypertension		
Allergies / Other			Immune System Disorder		
Anxiety			Infectious Disease, Current		
Asthma / Breathing Problem			Infectious Disease, Inactive		
Behavioral Problem			Lead Poisoning		
Bladder / Kidney Disorder			Menstrual Problem		
Bleeding / Clotting Disorder			Mental Health Diagnosis		
Bone / Joint / Muscular Disorder			Mobility Limitation		
Cancer			Mononucleosis		
Convulsions / Epilepsy / Seizure			Orthodontic Treatment		
COVID-19			Physical Education Restriction		
Depression			Psychological / Emotional Problem		
Dental Problem			Scoliosis		
Developmental Problem			Skin Condition		
Dizziness or Fainting			Soiling / Incontinence		
Diabetes			Speech Disorder		
Dietary Restriction			Surgery or Hospitalization		
Digestive / Bowel Problem			Tuberculosis		
Eating Disorder			Vision or Eye Disorder		
Endocrine Disorder			Weight Concern (Under/Overweight)		
Head or Spinal Injury			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 *Extreme* Shortness of Breath Chest Pain

Severe Lightheadedness / Dizziness

Coughing / Wheezing

Excessive Bruising 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.

Numbness / Tingling in

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. Date Parent / Guardian Signature

Appendix F-1A