

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 |
|-----------------------------------|--------------------------|------|
| ADHD                              | <input type="checkbox"/> |      |
| Allergies / Environmental         | <input type="checkbox"/> |      |
| Allergies / Food                  | <input type="checkbox"/> |      |
| Allergies / Insect Stings or Bees | <input type="checkbox"/> |      |
| Allergies / Latex                 | <input type="checkbox"/> |      |
| Allergies / Medications           | <input type="checkbox"/> |      |
| Anxiety                           | <input type="checkbox"/> |      |
| Asthma / Breathing Problem        | <input type="checkbox"/> |      |
| Autism                            | <input type="checkbox"/> |      |
| Behavior Concerns                 | <input type="checkbox"/> |      |
| Bladder / Kidney Disorder         | <input type="checkbox"/> |      |
| Bleeding / Clotting Disorder      | <input type="checkbox"/> |      |
| Bone / Joint / Muscular Disorder  | <input type="checkbox"/> |      |
| Cancer                            | <input type="checkbox"/> |      |
| Convulsions / Epilepsy / Seizure  | <input type="checkbox"/> |      |
| COVID-19                          | <input type="checkbox"/> |      |
| Depression                        | <input type="checkbox"/> |      |
| Dental Problem                    | <input type="checkbox"/> |      |
| Developmental Problem             | <input type="checkbox"/> |      |
| Dizziness or Fainting             | <input type="checkbox"/> |      |
| Diabetes                          | <input type="checkbox"/> |      |
| Dietary Restriction               | <input type="checkbox"/> |      |
| Digestive / Bowel Problem         | <input type="checkbox"/> |      |
| Eating Disorder                   | <input type="checkbox"/> |      |
| Endocrine Disorder                | <input type="checkbox"/> |      |
| Head or Spinal Injury             | <input type="checkbox"/> |      |

|                                   | YES*                     | DATE |
|-----------------------------------|--------------------------|------|
| Headaches / Migraines             | <input type="checkbox"/> |      |
| Hearing Problem                   | <input type="checkbox"/> |      |
| Heart Defect or Disease           | <input type="checkbox"/> |      |
| Hepatitis or Liver Problem        | <input type="checkbox"/> |      |
| Hernia                            | <input type="checkbox"/> |      |
| Hypertension                      | <input type="checkbox"/> |      |
| Immune System Disorder            | <input type="checkbox"/> |      |
| Infectious Disease, Current       | <input type="checkbox"/> |      |
| Infectious Disease, Inactive      | <input type="checkbox"/> |      |
| Lead Poisoning                    | <input type="checkbox"/> |      |
| Menstrual Problem                 | <input type="checkbox"/> |      |
| Mental Health Diagnosis           | <input type="checkbox"/> |      |
| Mobility Limitation               | <input type="checkbox"/> |      |
| Mononucleosis                     | <input type="checkbox"/> |      |
| Orthodontic Treatment             | <input type="checkbox"/> |      |
| Physical Education Restriction    | <input type="checkbox"/> |      |
| Psychological / Emotional Problem | <input type="checkbox"/> |      |
| Scoliosis                         | <input type="checkbox"/> |      |
| Skin Condition                    | <input type="checkbox"/> |      |
| Soiling / Incontinence            | <input type="checkbox"/> |      |
| Speech Disorder                   | <input type="checkbox"/> |      |
| Surgery or Hospitalization        | <input type="checkbox"/> |      |
| Tuberculosis                      | <input type="checkbox"/> |      |
| Vision or Eye Disorder            | <input type="checkbox"/> |      |
| Weight Concern (Under/Overweight) | <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 \_\_\_\_\_