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

	YES*	DATE
Headaches / Migraines	☐	
Hearing Problem	☐	
Heart Defect or Disease	☐	
Hepatitis or Liver Problem	☐	
Hernia	☐	
Hypertension	☐	
Immune System Disorder	☐	
Infectious Disease, Current	☐	
Infectious Disease, Inactive	☐	
Lead Poisoning	☐	
Menstrual Problem	☐	
Mental Health Diagnosis	☐	
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	☐	
Weight Concern (Under/Overweight)	☐	
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 ☐ *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_____