Office of Catholic Schools
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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	☐	
Allergies / Other	☐	
Anxiety	☐	
Asthma / Breathing Problem	☐	
Behavioral Problem	☐	
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: _____

☐ **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_____