

HOLY CROSS HIGH SCHOOL

PERSONAL HISTORY FORM

Parent/Guardian: Complete this side **BEFORE** submitting to your medical provider, and have MD initial consents below**

Student _____ Home Phone _____ Grade 9 10 11 12

Mother/Guardian _____ Work Phone _____ Cell Phone _____

Father/Guardian _____ Work Phone _____ Cell Phone _____

Complete the following by indicating any of the following, past or present. Include details on separate sheet, if necessary.

| | YES | NO | DATE | | YES | NO | DATE |
|--------------------------|-----|----|------|------------------------|-----|----|------|
| Allergies/Hay fever/Food | | | | Hepatitis | | | |
| Bee/Insect Sting Allergy | | | | Hernia | | | |
| ADD/ADHD | | | | Lung Disease | | | |
| Anemia | | | | Tuberculosis | | | |
| Asthma | | | | Measles | | | |
| Back/ Neck Injury | | | | Medication Allergies | | | |
| Bladder/Kidney problems | | | | Orthopedic problems | | | |
| Blood/Clotting Disorder | | | | Surgery | | | |
| Cancer/Leukemia | | | | Speech | | | |
| Chickenpox | | | | Vision | | | |
| Convulsions/Seizures | | | | Other: (explain below) | | | |
| Diabetes | | | | | | | |
| Head Injury/Concussion | | | | | | | |
| Headaches | | | | | | | |
| Hearing | | | | | | | |
| Heart/Murmur | | | | | | | |
| Rheumatic Fever | | | | | | | |

Please give details for any questions for which you have answered **YES** above: _____

Is the student undergoing medical care or treatment? Yes No / Explain: _____

Does the student take any medication (prescribed & or over- the – counter) Yes No Explain: _____

Has the student experienced any of the following **DURING/AFTER EXERCISE**? Circle all that apply:
 Fainting/Passing out Heat stroke Severe lightheadedness/Dizziness Coughing/Wheezing Chest Pain
 Excessive Bruising Extreme Shortness of breath Numbness/Tingling in _____

Yes No **CONSENT TO SHARE INFORMATION:** The school nurse has permission to share information provided in this report with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done on a “need to know” basis, in a confidential manner. This would include permission for communication between the health care provider and school nurse.
 ** Request Medical Provider Initial _____

Yes No **CONSENT FOR RELEASE OF RECORDS:** Holy Cross HS may provide a copy of immunization record/ medical report to institutions, such as colleges, transfer schools when requested by parent or student.

Yes **PERMISSION FOR OTC MEDICATIONS:** Cross out any medication that should **NOT** be given. Tylenol, Advil, Tums, Cough drops, First aid creams. ** Request Medical Provider Initial _____

DO NOT GIVE ANY MEDICATIONS (circle if you do not want your son to take any medication).

Parent/Guardian Signature _____ Date: _____

*** **Before submitting:** make a copy of the completed form for your records.
RETURN COMPLETED FORM TO THE SCHOOL NURSE BY AUGUST 1ST