HOLY CROSS HIGH SCHOOL

PERSONAL HISTORY FORM

Parent/Guardian: Complete this side <u>BEFORE</u> 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
Allergies/Hay fever/Food			
Bee/Insect Sting Allergy			
ADD/ADHD			
Anemia			
Asthma			
Back/ Neck Injury			
Bladder/Kidney problems			
Blood/Clotting Disorder			
Cancer/Leukemia			
Chickenpox			
Convulsions/Seizures			
Diabetes			
Head Injury/Concussion			
Headaches			
Hearing			
Heart/Murmur			
Rheumatic Fever			

	YES	NO	DATE
Hepatitis			
Hernia			
Lung Disease			
Tuberculosis			
Measles			
Medication Allergies			
Orthopedic problems			
Surgery			
Speech			
Vision			
Other: (explain below)			

Please give details for any questions for which you have answered <u>YES</u> 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 <u>DURING</u>/<u>AFTER</u> <u>EXERCISE</u>? 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: <u>Cross out</u> any medication that should <u>NOT</u> be given. Tylenol, Advil, Tums, Cough drops, First aid creams. ** Request Medical Provider Initial _____

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

Parent/Guardian Signature _____ Date: _____

***** <u>Before submitting</u>: make a copy of the completed form for your records.**

RETURN COMPLETED FORM TO THE SCHOOL NURSE BY AUGUST 1ST