

HEALTH HISTORY

St. Francis Borgia Regional High School

(Parents: Please complete this form, front and back, and return it to the school office by the 1st day of school.)

Student ID# _____
Name _____ Birth Date _____
Grade _____ Homeroom Teacher _____

Home Address _____ Home Phone _____
City _____ Zip Code _____
Father _____ Work Phone _____ Cell Phone _____
Mother _____ Work Phone _____ Cell Phone _____
Emergency Contact (other than parents)
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Does student have: Private health insurance: Yes ___ No ___ Medicaid: Yes ___ No ___ ID# _____

Doctor's Name _____ Physical Exam within the last 2 years? Yes ___ No ___
Dentist's Name _____ Dental exam within last 2 years? Yes ___ No ___
Is your child under an orthodontist's care? Yes ___ No ___ Doctor's name _____
Hospital preference _____

Dates of Immunizations: DTP/DTaP/DT/Td 1) _____ 3) _____ Polio 1) _____
2) _____ 4) _____ 2) _____
10 yr. Booster 5) _____ 3) _____
MMR 1) _____ Hep B 1) _____
2) _____ 2) _____
3) _____

DOES YOUR CHILD HAVE:

ALLERGIES

Allergies No ___ Yes ___ To drugs, food, insects, pollen? Please list: _____
Check symptoms that apply: Difficulty breathing/wheezing ___ Swelling of face,
throat, tongue ___ Hive or rash ___ Abdominal pain ___ Others _____
Bee sting Allergy No ___ Yes ___ Describe reaction: _____
Check symptoms that apply: Difficulty breathing/wheezing ___ Swelling of face,
throat, tongue ___ Hive or rash ___ Abdominal pain ___ Others _____
EPI-PEN JR. 015 MG Does your child have an Epi-Pen Jr.? Yes ___ No ___ If yes, where is it located
while your child is at school? Home ___; Backpack ___; Main Office ___

If you checked difficulty breathing or wheezing, swelling of face, throat or tongue, or hives or rash above, please consult your child's doctor regarding the possible need for an Epi-Pen to be with your child at all times for management of your child's allergy.

MEDICAL CONDITIONS

Asthma No ___ Yes ___ Triggered by: _____ Medications: _____
Date diagnosed: _____ MD Name: _____
Type of inhaler: _____ Inhaler used: Daily ____, or as needed ____
Inhaler is: with student ____, or home ____

Diabetes No ___ Yes ___ Date diagnosed: _____; MD Name: _____
Takes insulin: Yes ___ No ___

Epilepsy/
Seizures No ___ Yes ___ Describe seizure: _____
Date of last seizure: _____ Medications: _____

Heart Condition No ___ Yes ___ Describe: _____
Any physical restrictions? _____ Medications: _____

Bone/Joint
Condition No ___ Yes ___ Describe: _____
Any physical restrictions? _____ Medications: _____

Other information that will be helpful to us:

Take daily medications at home? No ___ Yes ___ At school? No ___ Yes ___ Emergency only? No --- Yes ___
Name of medication: _____ Dosage: _____ Time taken: _____
Reason for taking: _____

EYES: Glasses ___ (reading ___ distance ___) Contacts ___ Crossed ___ Lazy Eye ___ Difficulty seeing ___

EARS: Frequent ear infections ___ Tubes ___ Hearing difficulty (explain) _____
Wears hearing aid: Right ear ___ Left ear ___

OTHER CONCERNS:

Nosebleeds ___ Eating ___ Sleeping ___ Bowel ___ Skin ___ Dental ___ Blood disorder ___ Neurological ___
Lungs ___ Headaches ___ Menstruation ___ Phobias (fears) ___ ADD/ADHD ___ Blood Pressure ___

List any serious illnesses, injuries or surgeries: _____

Conditions that prevent PE participation: _____

Over-the-counter (OTC) Medication Permission

I give permission for designated school personnel to use peroxide and/or alcohol, apply topical creams (such as Caladryl, antibiotic ointment) and/or basic first aid treatments as appropriate. **NO** oral OTC medication, such as Ibuprofen, Acetaminophen, cough drops, Tums, etc. will be given to your child without a doctor's order.

Signature of Parent or Legal Guardian: _____ Date: _____

Confidentiality between Professionals

I give permission for designated school healthcare personnel to obtain information from my child's doctor, _____, MD for emergency purposes, and in order to comply with the State's mandatory immunization requirements for school attendance. Also, I give permission to share information regarding my child's health, as needed, with teachers and staff for my child's safety.

Signature of Parent or Legal Guardian: _____ Date: _____