Catholic Memorial School

HEALTH HISTORY and CONSENT FORM 2020-2021

Please print and complete this form. Once completed, you can scan and email it to AnneBatcheller@CatholicMemorial.org as an attachment or mail it to: Catholic Memorial School, 235 Baker Street, West Roxbury, MA 02132

Student's: Last Name First Name MI Date of Birth Grade

#1 Guardian/Parent's Name Phone #1 Phone #2 email

#2 Guardian/Parent's Name Phone #1 Phone #2 email

Name of Doctor Phone

Health Insurance Policy #

Does your son have:

Allergies: Yes ☐ No ☐ List ALL:

A prescribed Epi-Pen? Yes ☐ No ☐ Reason:

Asthma? Yes ☐ No ☐ A rescue inhaler? Yes ☐ No ☐

**Students with asthma and/or severe allergies must have an asthma/allergy action plan on file in the health office; and are required to carry their Epi-Pens & inhalers on their person at all times. Students are not permitted to carry any other medications.*

Please indicate if your son has a history of/currently has the following:

Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Seizures
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Heart Problems
Yes ☐ No ☐ Vision Problems
Yes ☐ No ☐ Hearing Problems
Yes ☐ No ☐ Depression
Yes ☐ No ☐ Anxiety
Yes ☐ No ☐ ADD/ADHD

Yes ☐ No ☐ Fainting
Yes ☐ No ☐ Migraine Headaches
Yes ☐ No ☐ Concussions
Yes ☐ No ☐ Blood Disorders
Yes ☐ No ☐ Frequent Nosebleeds
Yes ☐ No ☐ Scoliosis
Yes ☐ No ☐ Surgery/Hospitalization
Yes ☐ No ☐ Chronic illness
Yes ☐ No ☐ Positive Diagnosis of COVID-19

Other/Details:

Over

I grant permission for my son to be treated for illness/injury by the school nurse; and transported by EMS in the case of emergency.

Parent/Guardian Signature **Date**

I grant permission for my son to be administered the following medications by the school nurse:

Yes ☐ No ☐ Tylenol/acetaminophen
Yes ☐ No ☐ Motrin/ibuprofen
Yes ☐ No ☐ TUMS
Yes ☐ No ☐ Benadryl/Diphenhydramine
Yes ☐ No ☐ Zyrtec/cetirizine
Yes ☐ No ☐ Claritin/loratadine

Parent/Guardian Signature **Date**