



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
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#1 Guardian/Parent's Name	Phone #1	Phone #2	email
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#2 Guardian/Parent's Name	Phone #1	Phone #2	email
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Name of Doctor	Phone
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Health Insurance	Policy #
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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 <input type="checkbox"/> No <input type="checkbox"/> Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures Yes <input type="checkbox"/> No <input type="checkbox"/> High Blood Pressure Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Problems Yes <input type="checkbox"/> No <input type="checkbox"/> Vision Problems Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing Problems Yes <input type="checkbox"/> No <input type="checkbox"/> Depression Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety Yes <input type="checkbox"/> No <input type="checkbox"/> ADD/ADHD Other/Details: _____	Yes <input type="checkbox"/> No <input type="checkbox"/> Fainting Yes <input type="checkbox"/> No <input type="checkbox"/> Migraine Headaches Yes <input type="checkbox"/> No <input type="checkbox"/> Concussions Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Disorders Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent Nosebleeds Yes <input type="checkbox"/> No <input type="checkbox"/> Scoliosis Yes <input type="checkbox"/> No <input type="checkbox"/> Surgery/Hospitalization Yes <input type="checkbox"/> No <input type="checkbox"/> Chronic illness Yes <input type="checkbox"/> No <input type="checkbox"/> Positive Diagnosis of COVID-19
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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 ☐ Benadryl/Diphenhydramine

Yes ☐ No ☐ Motrin/ibuprofen

Yes ☐ No ☐ Zyrtec/cetirizine

Yes ☐ No ☐ TUMS

Yes ☐ No ☐ Claritin/loratadine

Parent/Guardian Signature

Date