CATHOLIC MEMORIAL SCHOOL

Health History and Consent Form 2020-21

Student's Last Name	Student's 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 ☐	List:
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 ☐	Fainting
Yes ☐	No ☐	Seizures	Yes ☐	No ☐	Migraine Headaches
Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐	Concussions
Yes ☐	No ☐	Heart Problems	Yes ☐	No ☐	Blood Disorders
Yes ☐	No ☐	Vision Problems	Yes ☐	No ☐	Frequent Nosebleeds
Yes ☐	No ☐	Hearing Problems	Yes ☐	No ☐	Scoliosis
Yes ☐	No ☐	Depression	Yes ☐	No ☐	Surgery/Hospitalization
Yes ☐	No ☐	Anxiety	Yes ☐	No ☐	Chronic Illness
Yes ☐	No ☐	ADD/ADHD	Yes ☐	No ☐	Positive Diagnosis of COVID-19

Other/Details: _____

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: _____

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

Parent/Guardian Signature _____ Date: _____