

# ACADEMY OF THE HOLY FAMILY

54 West Main Street; BAL TIC, CONNECTICUT 06330 \* Telephone: (860) 822-9272 \* Fax: (860) 822-1318  
 Health Aide: [Mrs. Patricia C. Penney](mailto:Mrs. Patricia C. Penney) \* Health Room E-Mail: [ppenney\\_health@ahfblatic.org](mailto:ppenney_health@ahfblatic.org)

**CONFIDENTIAL HEALTH HISTORY**

20\_\_\_\_\_ - 20\_\_\_\_\_

**(Forms may be E-Mailed, Faxed or Mailed to the Health Office listed above.)**

**Please include a copy of your daughter's Insurance Care (front and back).**

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Does your child have a history of the following?

My child has:     **Allergies** (Please specify below)                       **No Known Allergies**

Insects	Drugs	Food	Environmental

Does your child require an Allergy Injection Kit (EpiPen)?                       Yes     No

Does your child require Benedryl?     Yes     No

**PLEASE Check  Box If Your Child Has Now or Had any of the Following and Explain Below**

	Y	N		Y	N		Y	N		Y	N
Acne			Dental Problems			Heartburn			Pneumonia		
ADD / ADHD/ OCD			Depression			Hepatitis A			Rheumatic Fever		
Allergies			Dizziness			Hepatitis B			Rubella (German Measles)		
Anemia			Eating Disorder: Anorexia			Hepatitis C			Scarlet Fever		
Appendectomy			Eating Disorder: Bulimia			Hernia			Sickle Cell		
Anxiety			Eating Disorder: Purging			High or Low Blood Pressure			Sinusitis		
Arthritis			Ear Infections			Hives or Rashes			Thyroid		
Asthma			Eczema			IBS: Irritable Bowel Syndrome			Tourette's Syndrome		
Back Pain			Epilepsy			Incontinent			Tremors		
Bed Wetting			Excessive Fatigue			Joint Problems			Ulcers		
Bi-Polar			Fainting			Kawasaki Disease			Vision Problems		
Bladder Problems			Fifth Disease			Kidney Stones			Wears Glasses / Contacts		
Bronchitis			Frequent Headaches			Lyme Disease			Whooping Cough		
Cancer			Frequent Nose Bleeds			Malaria			Menstrual Problems:		
Chest Pain			Frequent Stomach Aches			Measles-Red ((Rubeola)			Irregular Periods		
Chicken Pox			Frequent Urinary Tract			Migraines			Cramps (Severe)		
Chills			Infections			Mononucleosis			Tuberculosis		
Chronic Colds			Head Injury			Nervousness			Treatment?		
Chronic Cough			Hearing Problems			Rheumatic Fever			Other (List Below)		
Constipation			Heart Disease			Panic Disorder					
Convulsions			Heart Murmur, Palpitations			Paralysis					

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**Reminder:** Failure to disclose any other condition concerning your child may result in improper care.

Print Name of **Parent/Guardian** completing form: \_\_\_\_\_ **Relationship to student:** \_\_\_\_\_

Signature of **Parent/Guardian** completing Form: \_\_\_\_\_ **Date completed:** \_\_\_\_\_

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## CONFIDENTIAL HEALTH HISTORY FROM (Continued)

Student: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

My child was in the hospital (other than birth): \_\_\_\_\_ Reason and When: \_\_\_\_\_


Is your child taking any prescription medication(s)?  Yes  No  
 If Yes, Please list below

No. My child does not take prescription medication.

**Reminder:** All prescription medication(s) require a Prescription Authorization Form for each prescription your child will take while at school. Must be signed by parent/guardian and your child's physician.

Name of Medicine	Amount/size of pill	How many pills or doses and when:
<i>Example: Dexadrine</i>	<i>10 mg.</i>	<i>_(1)_ morning ___ noon ___ dinner ___ bed</i>
		___ morning ___ noon ___ dinner ___ bed
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		___ morning ___ noon ___ dinner ___ bed

What over-the-counter medicines does your child take regularly?

- Vitamins (Please List): \_\_\_\_\_
- Herbal medicine(s) (please list): \_\_\_\_\_
- Other **Over-the-Counter** medicine like Tylenol, Advil, etc.? (Please list): \_\_\_\_\_

None, my child does not take any **Over-the-Counter** medicines regularly.

*\*Please note: Confidential information about your student's health may be shared only with other school staff that need to know to protect your child's safety. They are told to keep this health information private and not to share with anyone else. If there were health information, you would like not want to be shared, please contact the school health aide.*

Name of **Parent/Guardian** completing form: \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_

Signature of **Parent/Guardian** completing form: \_\_\_\_\_ **Date completed:** \_\_\_\_\_

Please turn page over

Page 2 of 2