ACADEMY OF THE HOLY FAMILY

54 West Main Street; BALTIC, CONNECTICUT 06330 * Telephone: (860) 822-9272 * Fax: (860) 822-1318
Email: schoolnurse@ahfbaltic.org

CONFIDENTIAL HEALTH HISTORY *(This is a onetime completion unless changes occur)*

Please contact Health Office with any changes at any time.

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

_____

_____

_____

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. Authorization form 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:
Example: Dexadrine	*10 mg.*	*_(1)__morning ___ noon ___dinner ___bed*
		___morning ___ noon ___dinner ___bed
		___morning ___ noon ___dinner ___bed
		___morning ___ noon ___dinner ___bed
		___morning ___ noon ___dinner ___bed
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		___morning ___ noon ___dinner ___bed
		___morning ___ noon ___dinner ___bed

Please list below any other Medical Professionals that may be needed for the care of your daughter.
Optometrist, Dentist, Psychologist, Psychiatrist or Counselor or any other potential needed.

Name_____Specialty_____Phone #:_____

Name_____Specialty_____Phone #:_____

Name_____Specialty_____Phone #:_____

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. Please contact the school nurse or administration with any concerns of this policy.*

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

Signature **of Parent/Guardian** completing form: _____ **Date competed:** _____

(Signatures will remain on file for the duration of enrollment @ AHF)