PMA
DISCOVER YOU.

Presentation of Mary Academy
Health History Form
2019-2020

Student's Name **DOB**_____

Gender: M___ **F**___ **Grade**____ **Student's Cell** _____

Student Lives With: _____

Address:_____

Parent/Guardian 1:_____ Relationship_____

Parent/Guardian 2:_____ Relationship_____

Home #_____Cell #_____

Employer: _____Work #_____

Guardian 2: _____ Relationship_____

Home #_____Cell #_____

Employer:_____Work #_____

Which Phone # to call **1st** _____ **2nd** _____ __

If guardian not available, please list individuals who we can release your child to:

	Name	**Relationship**	**Phone Numbers**	
1st	_____	_____	_____	_____
2nd	_____	_____	_____	_____

Allergies: No Allergies___ Environmental___ Bee/Insect___ Latex*___ Food___

(List)_____

Epipen Prescribed? Yes*___ No___ Has an Epipen ever been given? Yes*___ No___

Is an inhaler prescribed to your child? Yes*___ No___

All students with prescribed Epipens MUST have one stored in the nurse's office. It should be a single Epipen and labeled from the pharmacy. Student may also have one on their person. All students with inhalers must have an inhaler on their person or stored in the nurse's office. Both the Epipen and the Inhalers are important for your child's safety at school and we recommend one in the nurse's office and one carried by the student in their backpack.

Please list all medications taken daily, at home or in school, by your child:

Medication_____Dose_____Time_____

Medication_____Dose_____Time_____

Medication_____Dose_____Time_____

All Prescription Medications and all over the counter medications to be given at school need:

1. Written physician's orders
2. Written parental permission
3. Supplied and delivered by the parent in a pharmacy labeled container

MUST BE RETURNED NO LATER THAN AUGUST 8, 2019

PMA
DISCOVER YOU.

Name_____

Please check all conditions that apply:

___ADD/ADHD
___Anxiety
___Asthma
___Arthritis
___Autism Spectrum
___Bladder Control
___Celiac
___Constipation
___Diabetes
___Ear Infections
___Eyeglasses
___Gastric Reflux
___Hearing Loss
___Heart Condition
___Heart Murmur
___High Blood Pressure
___Kidney
___Lactose Intolerant
___Migraines
___Nosebleeds
___Seizures
___Scoliosis
___Previous fractures _____
___Strep Throat (History)
___*Hospitalizations this year?*
*Reason*_____
___*Previous Concussions*
*Dates*_____

___Emotional Concerns - Explain _____

_____

___Health Concerns - Explain _____

_____

Insurance Company:_____

Insurance Subscriber:_____

Policy Number:_____

Physician's Name:_____

Physician's Address:_____

Physician's Phone Number:_____

Dentist's Name:_____

Dentist's Address:_____

Dentist's Phone Number:_____

I give permission to the school nurse to speak with my above listed pediatrician or dentist to facilitate care of my child. ____ Yes ____No

Guardian's signature _____ Date _____

I give the nurse permission .<u>when needed,</u> to share information confidentially with appropriate personnel, to meet my child's health, safety and/or educational needs.

Guardian's signature _____Date_____

I give permission for my son/daughter to participate in *voluntary gym classes and activities* throughout the school year (ie- dodgeball, relay race and other outdoor activities on the school grounds).

Guardian's signature _____Date_____

MUST BE RETURNED NO LATER THAN AUGUST 8, 2019