



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
1 st	_____	_____	_____
2 nd	_____	_____	_____

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



Name _____

Please check all conditions that apply:

- ADD/ADHD Diabetes Kidney Strep Throat (History)
- Anxiety Ear Infections Lactose Intolerant
- Asthma Eyeglasses Migraines Hospitalizations this year?
- Arthritis Gastric Reflux Nosebleeds Reason _____
- Autism Spectrum Hearing Loss Seizures Previous Concussions
- Bladder Control Heart Condition Scoliosis Dates _____
- Celiac Heart Murmur Previous fractures _____
- Constipation High Blood Pressure
- 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 when needed, 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 _____

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