2020-2021 **Bishop Fenwick High School Health History** **Class of: _____**

PLEASE PRINT **To be Completed by Parent/Guardian**

_____

Student's Last Name **First Name** **Middle Initial** **Date of Birth: Month/Day/Year**

_____

Home Address: **Street** **City/Town**

_____

#1 Parent/Guardian Name **Home Phone #** **Work Phone #** **Cell Phone #**

_____

#2 Parent/Guardian Name **Home Phone #** **Work Phone #** **Cell Phone #**

Guardian is: Both Parents Father Mother Other: _____

The following persons reside locally and are authorized to act for parent in the event of illness/injury:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name of Doctor: _____ Phone: _____
Name of Dentist: _____ Phone: _____
Is your son/daughter covered by health insurance: **Yes** **No**
Insurance Name and Policy #: _____

Does your son/daughter have:

Allergies to Foods:	**No**	**Yes**	List: _____
Allergies to Medications:	**No**	**Yes**	List: _____
Other Allergies (bees, pollens, etc.):	**No**	**Yes**	List: _____
Does your son/daughter have an Epipen:	**No**	**Yes**	Reason: _____

List medication(s) that your son/daughter takes: _____

Has your son/daughter had:

Yes	**No**		**Yes**	**No**	
___	___	Asthma	___	___	Blood Disorders
___	___	Diabetes	___	___	Other
___	___	Heart/Blood Pressure Problems/Fainting	___	___	Heat Related Problems
___	___	Seizures	___	___	Fractures/Bone Injuries
___	___	Concussions/Head Injuries	___	___	Muscle Problems
___	___	Migraines	___	___	Scoliosis
___	___	Hearing/Vision Problems	___	___	Surgeries/Hospitalizations
___	___	Anxiety	___	___	Chronic Illness

Please comment on any questions to which you have answered "yes":

_____

_____

I give permission for my son/daughter to be treated for illness/injury in the nursing office. **Yes** **No**

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary. **Yes** **No**

My son/daughter has permission to receive:

acetaminophen (Tylenol)	**Yes**	**No**
ibuprofen (Advil)	**Yes**	**No**
calcium carbonate (Tums**)**	**Yes**	**No**

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs.

_____

Parent/Guardian Signature Date