Addendum A

SAINT JOSEPH SCHOOL HEALTH HISTORY (To be completed by parent/guardian) **School Year:**______________

Student Name ____ Sex _______ Date of Birth ____/____/_______
(Last, First, Middle Initial)

I. Life Threatening Allergic Conditions: (Check all that apply.)

[ ] Severe allergic reaction to Bee Stings, other insects:____
[ ] Severe reaction to Nuts, Peanuts: ____
[ ] Severe reaction to other Food Products: ____
[ ] Other severe allergies affecting school: ____

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does *not* indicate a severe allergic reaction.)
[ ] Itching and/or tightness in the throat, hoarseness
[ ] Itching or swelling of the eyes, lips, tongue or mouth
[ ] Shortness of breath, coughing, and/or wheezing
[ ] "Thready pulse", "passing out"/loss of consciousness
[ ] Hives

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? [ ]Yes* [ ]No
Specify medication: ____
* If you answered "Yes", it is strongly advised that he/she have this medication in school; it is **required** for interscholastic sports, (grades 5-8), with a physician's order specifying that he/she is able to "self administer" it. Carefully read the ***School Medication Policy*** below.

II. Health Conditions: Has your child been diagnosed by a physician with any of the following? Provide dates and details for all items checked "Yes".

Yes	Condition	Details/Dates
	Attention deficit: ___ ADD or ___ ADHD Date diagnosed ____________________ Meds: ___ Yes ___ No	
	Allergies to medications	
	Allergies (environmental or seasonal)	
	Asthma/Reactive Airway Uses an inhaler? ___ Yes ___ No Uses a nebulizer? ___ Yes ___ No If your child uses an inhaler, it may be advisable to have this medication in school; it is **required** for interscholastic sports, (grades 5-8), with a physician's order specifying that he/she is able to "self administer" it. Carefully read the ***School Medication Policy*** below.	
	Autism/PDD: ___Autism or ___Aspergers or ___PDD-NOS (not otherwise specified)	
	Bowel or digestive problem	
	Diabetes: Date diagnosed __________________ Insulin Dependent: ___ Yes ___ No	
	Heart problem: specify →	
	Hospitalizations: specify →	
	Kidney or urinary problem	
	Migraine headaches	
	Orthopedic problem (bone, joint)	
	Seizure disorder, Type ______________________________ Date of last seizure:____________________ Meds: ___ Yes ___ No. Medication ________________________ (Please provide physician documentation of diagnosis.)	
	Skin condition	
	Surgeries: specify →	
	Other:	

OVER

Yes	HEARING	
	Hearing loss: [ ] Right - ___Mild ___ Moderate ___Severe [ ] Left - ___Mild ___ Moderate ___Severe	Hearing loss due to ______________________________ Last evaluation __________________________________
	Hearing aid [ ] Right [ ] Left	

Yes	
	VISION
	Color deficiency
	Vision problem/Eye defect ____ Last eye exam _________________
	Wears glasses [ ] All the time [ ] For distance only [ ] For reading only [ ] For sports
	Wears contact lenses

III. Medications: (Include prescription and over-the-counter medication)

Name____ **Used to Treat**____

____ ____

____ ____

SCHOOL MEDICATION POLICY: If your child has a medical condition that requires medication in school, a written physician's order is required. No medication may be carried in school by a student; this applies to medications "over the counter" as well. The only exceptions are for those students with asthma inhalers and EpiPens whose order specifies that they may "self administer" their medication. All medication must be delivered to the school Health Office by the parent/ guardian with the physician's original order and written parental permission. Medication order forms are available through the Health Office or on the school website under the documents section.

IV. Special Needs

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?

[ ] Yes* [ ] No Specify: ____

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*** Any condition that would prevent full participation in educational programs (including physical education) requires physician documentation before modifications can be considered.**

I understand that if my child's health status changes during the school year, I will provide the Health Office with updated information.

Parent/Guardian Signature ____ Date ________________________