FONTBONNE HALL ACADEMY
9901 Shore Road, Brooklyn, NY 11209

PERSONAL HEALTH HISTORY

Parent/Guardian: Complete BEFORE submitting to your medical provider, and have MD initial consents below**

Student _____ **Home Phone** _____ **Grade** ___9___10___11___12

Mother/Guardian_____ **Home Phone** _____ **Cell Phone**_____

Father/Guardian_____ **Home Phone** _____ **Cell Phone**_____

CONDITION	YES	NO	DATE
Allergy – Food, Hay Fever, Medicine			
Allergy - Bee/Insect			
Anemia			
Asthma			
ADD-ADHD			
Back/Neck Injury			
Bladder/Kidney Problems			
Blood Clotting Disorder			
Chickenpox			
Convulsions/Seizures			
Heart Problems			
Diabetes			
Head Injury/Concussion			
Headache			
Hearing			

CONDITION	YES	NO	DATE
Rheumatic Fever			
Hepatitis			
Hernia			
Lung Disease			
Tuberculosis			
Measles			
Medication Allergies			
Orthopedic Problems			
Surgery			
Speech			
Vision			
Other: (explain below)			

Is the student undergoing medical care or treatment? _____ Yes ____ No / Explain:

_____

Does the student take any medication (prescribed & or over-the-counter) ____ Yes ____ No Explain:

_____

Has the student experienced any of the following DURING/AFTER EXERCISE? Circle all that apply: Fainting/Passing Out Heat Stroke Severe Lightheadedness/Dizziness Coughing/Wheezing Chest Pain Excessive Bruising Extreme Shortness of Breath Numbness/Tingling in _____

CONSENT TO SHARE INFORMATION: The school nurse has permission to share information provided in this report with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done on a "need to know" basis, in a confidential manner. This would include permission for communication between the health care provider and school nurse.
Yes_____No_____

**** Request Medical Provider Initial _____**

CONSENT FOR RELEASE OF RECORDS: Fontbonne Hall Academy may provide a copy of immunization record/medical report to institutions, such as colleges, transfer schools when requested by parent or student. Yes _____ No _____

PERMISSION FOR OTC MEDICATIONS: Cross out any medication that should NOT be given. Tylenol , Advil, Tums, Cough Drops, First Aid Creams. Yes_____ DO NOT GIVE ANY MEDICATIONS _____

Parent/Guardian Signature _____ **Date:** _____

*** Before submitting: make a copy of the completed form for your records. RETURN COMPLETED FORM TO THE SCHOOL NURSE