BC HIGH

1863

Class of: _____

BOSTON COLLEGE HIGH SCHOOL HEALTH HISTORY

To be completed by Parent or Guardian

Student's Last Name | First | Initial | Date of Birth

Home Address

#1 Parent/Guardian Name | Work # | Cell #

#2 Parent/Guardian Name | Work # | Cell #

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.

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

Name of Doctor: _____ Phone: _____

Is your son covered by Health insurance: Yes No

Name of Health Insurance Company: _____

Health Insurance Policy Number: _____

Does your son have:

Allergies to Foods: No Yes List: _____

Allergies to Medication: No Yes List: _____

Other Allergies (bees, pollens, etc): No Yes List: _____

Does your son have an Epipen/Emergency Epinephrine: No Yes Reason: _____

List medication(s) that your son takes: _____

Has your son had:

YES	NO		YES	NO	
___	___	Asthma	___	___	Hearing problems
___	___	Diabetes	___	___	Fainting
___	___	Heart/Blood Pressure Problems	___	___	Blood Disorders
___	___	Seizures	___	___	Fractures/Bone Injuries
___	___	Concussions/Head Injuries	___	___	Muscle Problems
___	___	Neurological/Mental Health Concerns	___	___	Scoliosis
___	___	Migraines	___	___	Surgeries/Hospitalizations
___	___	Vision Problems	___	___	Chronic Illness

Please comment on any questions to which you have answered "yes" or other health concerns:

_____

I grant my son permission to participate in the various athletic programs of Boston College High School and declare that he is physically and medically able to participate in such programs. I do not and will not hold BC High responsible and/or liable for any medical condition or injury my son might sustain while engaged in these activities.

I give permission for my son to be treated for illness/injury in the nursing office. My son has permission to receive:

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

_____

Parent/Guardian Signature Date

Please submit this form along with a copy of your recent physical exam including immunization to the Nurses' Office no later than July 1, 2020. FAX: 617-474-5095 EMAIL: nursesoffice@bchigh.edu