# ST. JOHN BOSCO PSR
# STUDENT'S HEALTH HISTORY & CONSENT FORM
# ACADEMIC YEAR 2018-2019

**Legal Last Name** _____ First Name_____ Middle Initial ____

**Medical Information:**

Hospital/Clinic Preference _____

Allergies/Special Health Considerations:

_____

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

_____ _____
Signature of Parent or Guardian Date

I give permission for my child to go on field trips. I release St. John Bosco PSR and individuals from liability in case of accident during activities related to St. John Bosco PSR, as long as normal safety procedures have been taken.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Witness Date

**FAMILY FACTORS**

**Mother:**
Title: Mr. Mrs. Ms. Dr.
Legal Last Name _____ First Name_____
☐ Married ☐ Divorced ☐ Remarried ☐ Single ☐ Widowed

**Father:**
Title: Mr. Mrs. Ms. Dr.

Legal Last Name _____ First Name_____
☐ Married ☐ Divorced ☐ Remarried ☐ Single ☐ Widowed

*Please complete back page*

Please check if any of your child's family members have any of the following conditions:

☐ Alcoholism
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Autism/Pervasive Developmental Delay (PDD)
☐ Central Auditory Processing Disorder (CAPD)
☐ Epilepsy
☐ Learning disability
☐ Intellectual & Developmental Disabilities
☐ Emotional disorder (depression, anxiety, bipolar disorder)
☐ Mental illness (mood disorder, personality disorder, psychotic disorder, etc.)
☐ Substance abuse

☐ Other serious condition: _____

**EMOTIONAL FACTORS**

Have there been any significant changes in your child's life such as divorce, death in the family, loss of employment, serious illness, and substance abuse, change of school or change of residence?

☐ Yes ☐ No

## PSYCHOLOGICAL INFORMATION

Has your child ever received any counseling? ☐ Yes ☐ No
Is your child receiving any counseling now? ☐ Yes ☐ No
Is your family receiving any counseling now? ☐ Yes ☐ No

Has your child been diagnosed as having any of the following:

☐ Aspergers' Syndrome
☐ Anxiety Disorder
☐ Attention Deficit Hyperactivity Disorder (ADHD)
☐ Autism
☐ Bi-Polar Disorder
☐ Central Auditory Processing Disorder (CAPD)
☐ Depression
☐ Intellectual disability
☐ Language impairment
☐ Learning disability
☐ Obsessive-Compulsive Disorder (OCD)
☐ Pervasive Developmental Delay (PDD)
☐ Speech impairment
☐ Tourette's Syndrome

☐ Other: _____

Please check all the characteristics that apply to your child:

| | |
|---|---|
| ☐ Affectionate | ☐ Indifferent |
| ☐ Aggressive | ☐ Low self esteem |
| ☐ Disorganized | ☐ Obedient |
| ☐ Distractible | ☐ Sad or Sullen |
| ☐ Fearful | ☐ Tantrums |
| ☐ Generally Happy | ☐ Tense |
| ☐ Hyperactive | ☐ Well-adjusted |
| ☐ Immature | ☐ Wets bed |
| ☐ Impulsive | |

☐ Other: _____