
ST. JOHN BOSCO PSR
STUDENT'S HEALTH HISTORY & CONSENT FORM
ACADEMIC YEAR (AY) 2019-2020

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 other side

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

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

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> Intellectual & Developmental Disabilities |
| <input type="checkbox"/> Autism/Pervasive Developmental Delay (PDD) | <input type="checkbox"/> Emotional disorder (depression, anxiety, bipolar disorder) |
| <input type="checkbox"/> Central Auditory Processing Disorder (CAPD) | <input type="checkbox"/> Mental illness (mood disorder, personality disorder, psychotic disorder, etc.) |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> 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:

- | | |
|--|--|
| <input type="checkbox"/> Aspergers' Syndrome | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Language impairment |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD) | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Obsessive-Compulsive Disorder (OCD) |
| <input type="checkbox"/> Bi-Polar Disorder | <input type="checkbox"/> Pervasive Developmental Delay (PDD) |
| <input type="checkbox"/> Central Auditory Processing Disorder (CAPD) | <input type="checkbox"/> Speech impairment |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tourette's Syndrome |

Other: _____

Please check all the characteristics that apply to your child:

<input type="checkbox"/> Affectionate	<input type="checkbox"/> Indifferent
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Low self esteem
<input type="checkbox"/> Disorganized	<input type="checkbox"/> Obedient
<input type="checkbox"/> Distractible	<input type="checkbox"/> Sad or Sullen
<input type="checkbox"/> Fearful	<input type="checkbox"/> Tantrums
<input type="checkbox"/> Generally Happy	<input type="checkbox"/> Tense
<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Well-adjusted
<input type="checkbox"/> Immature	<input type="checkbox"/> Wets bed
<input type="checkbox"/> Impulsive	

Other: _____

Please complete other side