

STUDENT HEALTH HISTORY (2025-2026)



***This form must be completed by a PARENT/GUARDIAN EVERY YEAR for EVERY STUDENT**

_____/_____/_____
Student's Last Name First Name Middle Date of Birth Grade

#1 Parent/Guardian Name (***Will be notified FIRST**) Phone #

#2 Parent/Guardian Name Phone #

Name of Primary Care Doctor/Clinic: _____ Phone: _____

Health Insurance: No Yes

Company: _____ Subscriber's name: _____ Policy Number: _____

ALLERGIES *Does your child have:

	NO	YES	PLEASE LIST
Allergies to FOODS?			
Allergies to MEDICATIONS?			
Allergies to OTHER? (Latex, Bees, Environmental)			

Does your child have an **EPI-PEN OR EPINEPHRINE AUTO-INJECTOR?** No Yes

For what Allergy? _____

***Please read** the **EXCEL STUDENT HEALTH INFORMATION** for medication requirements. Contact the **School Nurse** if you have any questions.

MEDICAL INFORMATION Please check **all** health conditions that relate to your child:

- Ear Infections (recent)
- Strep Throat (recent)
- Asthma
- Other Wheezing
- Nasal Allergies
- Nose Bleeds
- Migraines
- Headaches (other)
- Seizure Disorder
- Lactose Intolerance
- Constipation
- Celiac Disorder
- ADHD
- Anxiety
- Depression
- Autism Spectrum
- Emotional Concerns
- Scoliosis
- Other Bone Condition
- Kidney (Renal) Condition
- Heart (Cardiac) Condition
- Diabetes: Type 1 Type 2
- Bleeding Disorder
- Vision Problem:
- Glasses Contact Lenses
- Hearing Problem:
- Hearing Aid

Any **Hospitalizations?** No Yes

Reason: _____

Any **Surgeries/Procedures?** No Yes

Reason: _____

Any Previous **Concussions?** No Yes

Explain: _____

Please comment on any conditions which you have checked or **note any other health concerns** your child has:

Does your child have **ASTHMA** (OR OTHER CONDITION THAT CAUSES **WHEEZING**)? No Yes

if YES, does he/she use an **INHALER?** No Yes

***Please read** the **EXCEL STUDENT HEALTH INFORMATION** for medication requirements. Contact the **School Nurse** if you have any questions.

MEDICATIONS Please list ALL medications your child takes regularly (including those at home and at school).

MEDICATION NAME	DOSE	TIME(S) GIVEN	CONDITION

Will your child need to take **any prescribed medication at school?** No Yes

***If YES,** *Please read the **EXCEL STUDENT HEALTH INFORMATION** for **medication requirements**. Contact the **School Nurse** if you have any questions.

OVER-THE-COUNTER MEDICATIONS (GIVEN BY SCHOOL NURSE):

At times, students may not feel well while at school or may have a minor injury. The Health Office keeps several **over-the-counter medications** for use as needed when deemed necessary by the School Nurse. If given, parents are notified by phone, text or a note from the School Nurse. **Parents can give permission for administration of the following medications by checking the boxes and signing below:**

- Acetaminophen (Tylenol)
- Ibuprofen (Motrin, Advil)
- Diphenhydramine (Benadryl)
- Calcium Carbonate (TUMS)
- Antibiotic Ointment (for cuts/scrapes)
- Anti-itch cream (may contain hydrocortisone)
- Cough Drop/Throat Lozenges
- Vaseline or Lip Balm
- Cetirizine (Zyrtec)

Parent/Guardian Signature : _____ Date: _____

In the case of my child suffering life-threatening or potentially life-threatening injuries or illness while at school or a school-related event, I hereby acknowledge and understand that Excel Academy staff shall notify appropriate emergency responders to treat and take my child to a hospital, doctor, or dentist without my additional prior consent. I also release Excel Academy Charter School and its employees, trustees, contractors, volunteers, or agents from any and all liability arising from their acts or omissions related to these notifications and treatment.

Parent/Guardian Signature: _____ Date: _____

I authorize Excel Academy Charter School (including School Nurses, School Nurse teachers, or other authorized and qualified staff) **to test my student or legal charge for COVID-19.** I understand that this testing may occur multiple times. I understand that COVID-19 testing may create protected health information and other personally identifiable information of the student, and such information will only be accessed, used and disclosed in accordance with HIPAA and applicable law. I authorize Excel to transmit such PHI to the Department of Public health and the Executive Office of Health and Human Services, as authorized under HIPAA. This authorization will remain in full force and effect unless and until such time as I contact the school to revoke this authorization, such revocation to be provided in writing. By signing this form, I am attesting that I have the requisite legal authority and power to make the decisions for, and on behalf of, the student named above.

Parent/Guardian Signature: _____ Date: _____

PLEASE RETURN THIS COMPLETED FORM, PHYSICAL EXAM FORM AND IMMUNIZATION RECORDS TO YOUR CHILD'S SCHOOL

Excel Academy Charter High School 401 Bremen Street Boston, MA 02128 P: 617-326-3574 F: 617-674-3427 dweaver@excelacademy.org	Excel Academy East Boston Campus 58 Moore Street Boston, MA 02128 P: 617-874-4093 F: 617-419-1122 jharty@excelacademy.org	Excel Academy Greenway Campus 375 Bremen Street Boston, MA 02128 P: 617-561-1371 F: 617-674-3429 lbarrett@excelacademy.org	Excel Academy Chelsea Campus 180 2 nd Street Chelsea, MA 02150 P: 617-336-9970 F: 617-399-6867 kfarren@excelacademy.org	Excel Academy RI Campus 622 Woonasquatucket Ave North Providence, RI 02911 P: 401-680-6086 blavallee@excelacademy.org
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