

STUDENT HEALTH HISTORY (2026-2027)



***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

Any **Surgeries/Procedures?** No Yes

Any Previous **Concussions?** No Yes

Reason: _____

Reason: _____

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 or if you wish to allow for all medication just sign 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: _____

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

Excel Academy Charter HS 401 Bremen Street Boston, MA 02128 P: 617-326-3574 F: 617-674-3427 dweaver@excelacademy.org	Excel Academy East Boston 58 Moore Street Boston, MA 02128 P: 617-874-4093 F: 617-419-1122 jharty@excelacademy.org	Excel Academy Greenway 375 Bremen St Boston, MA 02128 P: 617-561-1371 F: 617-674-3429 lbarrett@excelacademy.org	Excel Academy Chelsea 180 2 nd Street Chelsea, MA 02150 P: 617-336-9970 F: 617-399-6867 kfarren@excelacademy.org
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Excel Academy RI Middle School 622 Woonasquatucket Ave North Providence, RI 02911 P: 401-680-6086 blavallee@excelacademy.org	Excel Academy RI High School 291 Westminster Street Providence, RI 02903 P: 615-513-3730 F: 401-213-8551
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