



**Cathedral Academy**  
3790 Ashley Phosphate Rd.  
Charleston, SC 29418

**STUDENT HEALTH INFORMATION**  
**2022-23 School Year**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**Please indicate if your child has had any of the following by checking below:**

**ALLERGIES**

Allergy Type

Food List food (s) \_\_\_\_\_ Reaction \_\_\_\_\_

Medication List Medicines \_\_\_\_\_ Reaction \_\_\_\_\_

Bee sting \_\_\_\_\_ Reaction \_\_\_\_\_

Other (list) \_\_\_\_\_

Reactions Type  Mild  Severe Date of last severe reaction \_\_\_\_\_

Coughing  Hives

Difficulty breathing  Generalized swelling

Nausea  Local Swelling

Wheezing  Rash

Other \_\_\_\_\_

Currently prescribed medications and treatments: (Please state name, dose, time, frequency, and route)

Oral antihistamine (Benadryl, etc.)  Epinephrine  Other \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

**FOOD INTOLERANCE**

Due to Gastrointestinal (Digestive) distress: List foods \_\_\_\_\_ Reaction \_\_\_\_\_

Due to Religious preferences: List foods \_\_\_\_\_ Reaction \_\_\_\_\_

**ASTHMA**

Triggers:  Exercise  Environmental  Other (list) \_\_\_\_\_

Symptoms:

Chest tightness, discomfort, or pain  Difficulty breathing  Throat itch, tightness, or soreness

Coughing  Hoarseness  Wheezing

Other \_\_\_\_\_

Medications used (name, dose, frequency, route): \_\_\_\_\_

Last asthma episode (date): \_\_\_\_\_

Have you submitted an Asthma Action Plan? (must be completed by your child's Doctor)  YES  NO

Physical Limitations: \_\_\_\_\_

Is there anything concerning the health of your child which the school should know.

If yes, please specify: \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*By signing this form, I acknowledge the responsibility of providing the school with accurate and updated information throughout the school year as it changes.*

***PLEASE BE AWARE:***

*In order to follow DHEC regulations, we can only accept medication that is in an appropriately labeled prescription bottle. Medications must be brought to the school by the parent in the original containers with original labels intact. (Most pharmacies will divide medications and provide additional containers upon request for this purpose.) Over-the-counter (OTC) medication, including Tylenol, cannot be administered without a prescription label and must be administered by a member of the faculty/staff.*

- 1. The parent must furnish the medication.*
- 2. The parent must complete a **Physician/Parent Medication Authorization Form** indicating the date, dosage, and time to be administered.*
- 3. Students may not carry prescriptions or OTC medications on their person without expressed written permission from their physician, parents, and the administration. (Example: inhalers and epi-pens.)*
- 4. A form, available in the school office or online, must be filled out by the Physician before medicine can be administered.*