

CATHOLIC SCHOOL HEALTH REPORT

A health examination is required for all first time entrants or all new students to the school. This information is required prior to the 1st day of school to be complete. For participation in sports, this physical examination is required each year to be completed after June 1, for the upcoming school year.

(Physical and completed sports packet is required before student can practice and/or play any sport)

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN

Entering Grade _____ Year _____

CHILD NAME: _____ SEX: M F BIRTHDATE: _____
First Middle Last Month Day Year

ADDRESS: _____
Street City ZIP CODE

MOTHER'S NAME: _____ PHONE: _____
First Middle Last Home Work

FATHER'S NAME: _____ PHONE: _____
First Middle Last Home Work

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:

Name	Relationship	Telephone Number (s)
1)		
2)		

PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER (S) OF THOSE WHO MAY PICK THIS CHILD UP FROM THIS SCHOOL:

Health History: (Please explain any yes answers)

- a) Any known chronic illness: Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: _____ No: _____
- b) Any known allergies: drug, environmental, food; describe: Yes: _____ No: _____
- c) History of head injury, concussion, seizure, etc? Yes: _____ No: _____
- d) History of any hospitalization or surgery; explain Yes: _____ No: _____
- e) Any spinal injuries or spinal defects: Yes: _____ No: _____
- f) List all medications taken on a daily basis: _____
- g) Note special concerns regarding participation in physical education, athletics or sports for your child: _____
- h) Does your child wear contact lens (eyes) or have any orthodontic appliance in his/her mouth? Yes: _____ No: _____
- i) Any recurrent skin rashes, abscesses in past year? (explain) Yes: _____ No: _____

*****SPECIAL EMERGENCY REFERRAL INSTRUCTIONS*****

In the event I cannot be reached or make arrangements for emergency medical attention at the time of illness/accident, I hereby authorize:

_____ to take my child to:

NAME OF SCHOOL

PHYSICIAN

ADDRESS

TELEPHONE

HOSPITAL

ADDRESS

TELEPHONE

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

THIS SIDE TO BE COMPLETED BY PHYSICIAN **Student's Name** (PLEASE PRINT) _____

Relevant Health Information	Physical Assessment	Normal	Abnormal	Not Examined
Present Age: yrs. mos.	General Appearance			
Height (no shoes): inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	1) Reflex Test			
	2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck (lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: _____

IMMUNIZATION RECORD

month/day/year

Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Booster	Booster
DPT/DTap/Td/DT (diphtheria, pertussis, tetnus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Hepatitis A						
PCV7						
Meningococcal Vaccine						

Tuberculin Skin Test; Date:		Result:		Chest X-ray; Date:		Result:		
Hearing Screening	1st Screening		Hearing Screening		2nd Screening		1st Vision Screening	2nd Vision Screening
	at 25 dB	R	L	at 25 dB	R	L		
1000 Hz			1000 Hz			Distance Acuity: R-20/____ L-20/____	Distance Acuity: R-20/____ L-20/____	
2000 Hz			2000 Hz			Pass ____ Refer ____	Pass ____ Refer ____	
4000 HZ			4000 HZ			Fail ____	Fail ____	
Date:			Date:			Signature:	Signature:	

Scoliosis Screening: Pass:_____ Fail:_____ Refer:_____ Comments:_____

Patient Health History, Findings, and Recommendations:

Physical Activity: Restricted or Unrestricted (circle one) Explanation:

I have examined the child named on this form, and find that he/she is able to participate in the athletic programs of the school:

Date: _____ Signature: _____
(Stamped signature not accepted)

Please print physician's name and address: _____
(MD / DO or PA or RNP working under the direction of a licensed physician)