

CATHOLIC SCHOOL HEALTH REPORT

DIOCESE OF FT. WORTH

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

ADDRESS: _____
Street City ZIPCODE

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

FATHER'S NAME: _____ TELEPHONE: _____
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 their 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'S 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, tetanus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Hepatitis A						
PCV7						
Meningococcal Vaccine						
HPV (Gardasil)						

Tuberculin Skin Test; Date: _____ Result: _____ Chest X-ray; Date: _____ Result: _____

BCG, Date: _____

Hearing Screening at 25 dB	1 st screening		Hearing Screening at 25 dB	2 nd screening		1 st Vision Screening	2 nd Vision Screening
	R	L		R	L		
1000 Hz			1000 Hz			Distance Acuity: R20/____ 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)