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 on or 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 Zip code

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

FATHER'S NAME: _____ TELEPHONE: _____ _____
First Middle Last Home/Cell 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 A						
Hepatitis B						
Varicella						
Pneumococcal Conjugate (PCV)						
Meningococcal ACWY						

Hearing Screening	1st screening		Hearing Screening	2nd screening	
at 25 dB	R	L	at 25 dB	R	L
1000 Hz			1000 Hz		
2000 Hz			2000 Hz		
4000 Hz			4000 Hz		
Date:			Date:		

1st Vision Screening
Distance Acuity:
R20/_____ L-20_____
Pass_____ Refer_____
Fail _____
Signature:

2nd Vision Screening
Distance Acuity:
R-20/_____ L-20/_____
Pass_____ Refer_____
Fail _____
Signature:

Spinal 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) 8/18