

**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 1<sup>st</sup> 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 A						
Hepatitis B						
Varicella						
Pneumococcal Conjugate						
Meningococcal Vaccine						
HPV (Gardasil)						

Tuberculin Skin Test; Date: \_\_\_\_\_ Result: \_\_\_\_\_ Chest X-ray; Date: \_\_\_\_\_ Result: \_\_\_\_\_

BCG; Date: \_\_\_\_\_

Hearing Screening	1 <sup>st</sup> screening		Hearing Screening	2 <sup>nd</sup> screening		1 <sup>st</sup> Vision Screening	2 <sup>nd</sup> Vision Screening
at 25 dB	R	L	at 25 dB	R	L	Distance Acuity:	Distance Acuity:
1000 Hz			1000 Hz			R20/ ____ L-20/ ____	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)