CATHOLIC SCHOOL HEALTH REPORT

THIS SIDE TO BE COMPLETED BY PARENTS **Entering Grade_____ Year_____**

CHILD'S NAME_____ **SEX: M F** **D.O.B** _____/_____/_____
First Middle Last Circle One Month Day Year

ADDRESS:_____
Street City Zip

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

FATHER'S NAME: _____ **TELEPHONE**: _____
First 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 **Yes_____ No_____**

G) Note special concerns regarding participation in physical education, athletics or sports for your child

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SPECIAL EMERGENCY REFERRAL INSTRUCTIONS

In the event I cannot be reached or make arrangements for emergency medical attention at the time of illness or accident, I hereby authorize Saint Anthony School to take my child to:

DOCTOR **ADDRESS** **TELEPHONE#**

DOCTOR/CLINIC/HOSPITAL **ADDRESS** **TELEPHONE#**

Date of last Tetanus Shot:_____

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

THIS SIDE TO BE COMPLETED BY PHYSICIAN STUDENTS NAME (Please Print)

Relevant Health Information	Physician Assessment	Normal	Abnormal	Not Examined
Present Age yrs. mos.	General Appearance			
Height (No Shoes) inches	Skin			
Weight (Light Clothes) 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	Dose3	Dose 4	Booster	Booster
DPT/DTaP/Td (diphtheria, pertussis, tetanus)						
Polio (OPC/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Other						

Tuberculin Skin Test: Date:_____ **Results:**_____**Chest X-Ray: Date:**_____**Results:**_____

Scolliosis Screening: Pass:_____ **Fail:**_____**Refer:**_____**Comments:**_____

Hearing Screening	1st Screening		Hearing Screening	2nd Screening		1st Vision Screening	2nd Vision Screening
	R	L		R	L	Distance Acuity	Distance Acuity
at 25dB			at 25dB			R20/____ L20/	R20/ L20/
1000 Hz			1000 Hz			Pass_____	Pass_____
2000 Hz			2000 Hz			Refer_____	Refer_____
4000 Hz			4000 Hz			Fail_____	Fail_____
Date:			Date:			Signature:	Signature:

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 acceptable)

Please print physician's name address:_____

(MD/DO or PA or RNP working under the direction of a licensed physician)