CATHOLIC SCHOOL HEALTH REPORT ARCHDIOCES OF ATLANTA

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 MM/DD/YYYY

ADDRESS: ____
Street City Zip code

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 you child:

____

h) Does your child wear contact lens (eyes) or have any orthodontic appliance in their mouth? Yes: _____ No: ____

____

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

In the event that 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 #

Date of last Tetanus shot: ___________

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 (diphtheria,pertussis,tetanus)						
Polio (OPV/IPV)						
MMR/M (Measles, Mumps, Rubella)						
Hib CV (Haemophilus)						
Hepatitis B						
Varicella						
Other						

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

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:

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 and physical education 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)