CATHOLIC SCHOOL HEALTH REPORT

DIOCESE OF FORT WORTH

A health examination is required for all first time entrants or all new students to the school. This information must be turned in at registration 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.

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: ___

*** *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 hearby authorize: ____ to take my child to:

NAME OF SCHOOL

____

PHYSICIAN ADDRESS TELEPHONE #

____

HOSPITAL ADDRESS TELEPHONE#

Date of last Tetanus Shot: _______

PARENT / GUARDIAN'S SIGNATURE: ______________________________________ Date: _______

1/03