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 after June 1, for the upcoming school year.

(Physical and completed sports packet is required before student can practice and / or play any sport)

HS SI	IDE TO BE COMPL	ETED BY PARE	NT/GUARDIA	N	Enterin	g Grade _.		Year_
CHILE	D'S NAME:		SEX: M	F BIR	THDATE	:		
	First N	Middle Last				Month	Day	Year
ADDR	RESS:	Street	City			ZI	IPCOD	E
MOTH	HER'S NAME: First	Middle	_		HONE: _	Home		Work
FATH	ER'S NAME:			_TELEP	HONE: _			
	First SE OF EMERGENCY I		Last	RE REAC	HED DI	Home		Work
	Name		Relationship), i	Telephon		ber(s)
1)				<u> </u>				
2)								
PLEA	SE LIST NAME, RELAT	TIONSHIP AND TEL	EPHONE NUMB	ER(S) OF	THOSE	WHO MAY	PICK	THIS CH
	ROM THIS SCHOOL: _							
lealth	<u> History</u> : (Please explai	in any yes answers)						
a) A	ny known chronic illnes	s: Asthma. Cvstic Fi	brosis. Diabetes.	Heart, etc	C.	Y	es:	_ No:
<i>'</i>								
o) A	ny known allergies; dru	g, environmental, fo	od; describe:					_ No:
c) H	istory of head injury, co	ncussion, seizure, e	etc?			Y	es:	_ No:
d) H	listory of any hospitaliza	ation or surgery; exp	lain:			Y	es:	No:
e) Ā	Any spinal injuries or spi	nal defects:				Y	es:	_ No:
f) L	ist all medications taker	n on a daily basis:						
g)	Note special concerns re	egarding participatio	n in physical educ	ation, ath	nletics or s	sports for yo	our chil	d:
h) [Does your child wear co	ntact lens (eyes) or	have any orthodo	ntic applia	ance in th	eir mouth?	Yes: _	No:
i) A	Any recurrent skin rashe	s, abscesses in pas	t year? (explain)				Yes	_ No _
_		*** SPECIAL EMERG	ENCY REFERRAL	INSTRUC	TIONS ***			
	ent I cannot be reached o	or make arrangement	s for emergency m	nedical at	tention at	the time of i	illness/	
cident,	I hereby authorize:					to take	mv ch	ild to:
			NAME OF S	CHOOL			,	
PHYSICIAN ADDRESS		RESS				TELEPHONE #		
HOSPITAL ADDRESS			RESS	TELEPHONE#				
'AREN	IT / GUARDIAN'S SIGNA	TURE:				Date:		

Present Age: yrs. mos. General Appearance	Examined	
Height (no shoes):		
Regint (light clothing): Bis. oz. (%) Head		
Expansion of Abnormal Findings: Eyes:		
2) Cover Test		
Other: Ears Nose, Mouth, Pharynx, Teeth Pulse / Respiration: Neck(lymphatiothyroid)		
Nose, Mouth, Pharynx, Teeth		
Pulse / Respiration: Neck(lymphatic/thyroid) Heart		
Heart Lungs Abdomen (include hemias)		
Lungs Abdomen (include hemias) Centification of Abnormal Findings:		
Abdomen (include hemias) Genitalia Orthopedic Neurologic Explanation of Abnormal Findings: IMMUNIZATION RECORD month/day/year month/day/ye		
Genitalia Orthopedic Neurologic Explanation of Abnormal Findings: IMMUNIZATION RECORD month/day/year month/		
Orthopedic Neurologic Explanation of Abnormal Findings:		
Neurologic Neu		
Explanation of Abnormal Findings:		
IMMUNIZATION RECORD		
Dose 1 Dose 2 Dose 3 Dose 4 Booster		
Polio (OPV/IPV) MMR/M (Measles, Mumps, Rubella) Hib CV (Haemophilus) Hepatitis B Jericella Pneumococcal Conjugate Meningococcal Vaccine HPV (Gardasii) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: 3CG, Date: Hearing Screening	Booster	
MRRM (Measles, Mumps, Rubella) dib CV (Haemophilus) depatitis A depatitis B Preumococcal Conjugate Meningococcal Vaccine depreumosoccal Vaccine		
Hepatitis A Hepatitis B Hepatitis B Hepatitis B Hepatitis B Herotococcal Conjugate Herotococcal Vaccine HPV (Gardasil) Fuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: Hearing Screening I streening Hearing Screening Screening I screening I screening I too Hearing Screening I too		
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 Screening Screening Screening Screening Screening At 25 dB R L at 25 dB R L Distance Acuity: Distance Acuity: 1000 Hz 1000 Hz 2000 Hz Pass Refer Pass Refer Signature: Scollosis Screening: Pass Fail Refer Comments: Patient Health History, Findings and Recommendations: Physical Activity: Restricted or Unrestricted (circle one) Explanation: Thave examined the child named on this form, and find that he/she is able to participate in the athletic programs		
Hepatitis B Varicella Pneumococcal Conjugate Meningococcal Vaccine HPV (Gardasil) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: BCG, Date: Hearing Screening Ist screening Screening Screening Screening Ist Vision Screening Distance Acuity: Distance Acuity: Distance Acuity: Re20/L-20 R-20/L-20 R-2000 Hz		
Varicella Pneumococcal Conjugate Meningococcal Vaccine HPV (Gardasil) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Resu		
Pneumococcal Conjugate Meningococcal Vaccine HPV (Gardasii) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: BGG, Date: Hearing Screening Hearing Screening Screening Screening Screening At 25 dB R L at 25 dB R L Distance Acuity: Distance Acuity: R-20/L-20 R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/R-20/		
Meningococcal Vaccine HPV (Gardasil) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: Result: Chest X-ray; Date: Result: Result: Rearing Screening Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: Result: Result: Rearing Screening		
Her (Gardasil) Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: GCG, Date: Hearing Screening Screen		
Tuberculin Skin Test; Date: Result: Chest X-ray; Date: Result: BCG, Date: Hearing Screening Ist screening Screening Screening Screening Ist Screening Screening Ist		
Hearing Screening		
Hearing Screening 1st screening 2nd screening 2nd screening 2nd Vision Screening		
Screening Screening Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: Distance Acuity: R20/L-20 R-20/L-20 R-20/	oning	
1000 Hz		
2000 Hz		
A000 Hz	R-20/ L-20/	
A000 Hz	Pass	
Date: Scoliosis Screening: Pass Fail 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	Refer	
Scoliosis Screening: Pass Fail 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	l dii	
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	Signature:	
I have examined the child named on this form, and find that he/she is able to participate in the athletic programs		
Date: Signature:	of the scho	
DateSignature		
(Stamped signature not accepted)		