CATHOLIC SCHOOL HEALTH REPORT ARCHDIOCESE OF ATLANTA

A health examination is required for all first time entrants or all new students to the school. This information is required prior the 1st day of school to be complete. For participation in sports, this physical examination is required each year to be complet 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 U 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			

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)