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 to be complete prior to the 1st day of school. For participation in sports, this physical examination is required to be completed each year 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

_____
Cell Phone Number

FATHER'S NAME: _____ TELEPHONE _____ _____
First Middle Last Home Work

_____
Cell Phone Number

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 his/her mouth? Yes: _____ No: ____

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

In the event of a medical emergency warranting immediate medical care, EMS (911) will be called and parents will be responsible for all incurred expenses.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

See Other Side – To be Completed by Physician

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: _____

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)

See Other Side – To be Completed by Parent