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)*

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:___

i) Any recurrent skin rashes, abscesses in past year? (explain) 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:** _____