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 on or after the THIRD Saturday of May (May 20, 2023), for the upcoming school year.

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

FATHER'S NAME: Tirst Middle Last Home/Cell IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL: Name Relationship Telephone Number(s) 1) PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHUP FROM THIS SCHOOL: Health History: (Please explain any yes answers) a) Any known chronic illness; Asthma, Cystic Fibrosis, Diabetes, Heart, etc. Yes: No: No: No: No: No: No: No: No: No: No												
First Middle Last City Zip code MOTHER'S NAME: Street City TELEPHONE: Home/Cell Moth Name Street Middle Last TELEPHONE: Home/Cell Moth Name Middle Last TELEPHONE: Home/Cell Middle Last TELEPHONE: Home/Cell Middle Last TELEPHONE: Home/Cell Middle Last TELEPHONE: Home/Cell Middle Last Name Name Relationship Telephone Number(s) Telephone Number(s) 1)	HOSPITAL			ADDRESS			٦			TELEPHONE#		
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First Middle Last Street Street City TELEPHONE: Home/Cell WARTHER'S NAME: First Middle Last First Middle Last First Middle Last TELEPHONE: First Middle Last IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL: Name Relationship Telephone Number(s) 1) PLEASE LIST NAME, RELATIONSHIP AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK THIS CHILUP 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? Mistory of any hospitalization or surgery; explain: PLIST NAME (Please explain any yes answers) Any spinal injuries or spinal defects: Yes: No: Telephone Number(s) WHO MAY PICK THIS CHILUP FROM THOSE WHO MAY PICK THIS CHILUP FROM THIS CHIL	i)	Any recurrent	skin rashes,	abscesses	in past year	? (explain)			,	Yes	_ No	
First Middle Last City Zip code Street City TELEPHONE:		Does your chil	ld wear conta	act lens (ey	es) or have a	any orthodo	ntic a	appliance in t	heir mouth	? Yes:	No:	_
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ADDRESS:	d)	History of any	hospitalizatio	on or surge	ry; explain:					Yes:	No: _	<u>-</u>
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THIS SIDE TO BE COMPLETED BY PHYSICIAN Relevant Health Information				Assessment	(PLEASE PRINT) Normal	Abnorr	nal No	Not Examined	
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			Ears						
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ion:			Neck(lymp	ohatic/thyroid)					
			Heart						
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			Abdomen	(include hernias)				
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vity: Restri	cted or Uni	estricted	(1)						
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ned the chi	ld named c	n this fo	rm, and fin		is able to partic	ipate in the a	thletic program	s of the scho	
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	ion: of Abnor NRECORD T (diphtheria, s, Mumps, Rushilus) conjugate (PC	s): inches (Shing): lbs. oz. (lematocrit (opt): Idenatocrit (opt	ion: Inches (%) Inches (%)	s): inches (%) Skin hing): lbs. oz. (%) Head lematocrit (opt): Eyes: 1) F 2) C Ears Nose, Morion: Neck(lymp Heart Lungs Abdomen Genitalia Orthopedi Neurologic Necrons NRECORD S Dose 1 T (diphtheria, pertussis, tetanus) Conjugate (PCV) CWY 1st screening R L 1000 Hz 2000 Hz 4000 Hz Date:	s): inches (%) Skin hing): lbs. oz. (%) Head lematocrit (opt): Eyes: 1) Reflex Test 2) Cover Test Ears Nose, Mouth, Pharynx, Te ion: Neck(lymphatic/thyroid) Heart Lungs Abdomen (include hernias Genitalia Orthopedic Neurologic of Abnormal Findings: NRECORD S T (diphtheria, pertussis, tetanus) T (diphtheria, pertussis, tetanus) s, Mumps, Rubella) shilus) 1st screening R L at 25 dB R L 1000 Hz 2000 Hz 4000 Hz Date:	Skin Skin	Skin Skin	Skin Skin	