

DIOCESE OF TUCSON CATHOLIC SCHOOLS

Student Health History

THIS SECTION TO BE COMPLETED BY PARENT

Today's Date _____

Child's Entering Grade _____

Student's Name _____
Last First M.I.

DOB _____

Known Medication Allergies _____

Known Food Allergies _____

Has your child ever had any of the following?

| Condition | Yes, Date | No | Condition | Yes, Date | No | Condition | Yes, Date | No |
|----------------------|-----------|----|----------------------|-----------|----|------------------|-----------|----|
| Allergies (Seasonal) | | | Hearing Problems | | | Rheumatic Fever | | |
| Anemia | | | Heart Problems | | | Scoliosis | | |
| Asthma | | | Hepatitis | | | Seizures | | |
| Back Pain | | | Hernia | | | Sinus Problems | | |
| Chicken Pox | | | Hives | | | Strep Throat | | |
| Concussion | | | Joint Pain/Arthritis | | | Stomach Problems | | |
| Diabetes | | | Kidney Problems | | | Tuberculosis | | |
| Eczema | | | Menstrual Cramps | | | Valley Fever | | |
| Emotional Problems | | | Migraine Headaches | | | Vision Problems | | |
| Fainting | | | Mononucleosis | | | Other | | |

| | Description | Year | | Description | Year |
|------------|-------------|------|--|-------------|------|
| Operations | | | | | |
| Operations | | | | | |
| Sprains | | | | | |
| Fractures | | | | | |

Does your child wear glasses or contact lenses? _____ Date of last Tetanus Booster _____

If your child is currently under a doctor's treatment, please explain and give doctor's name: _____

Medications now taking _____

If medications are to be given at school, complete "Parent Consent for Giving Medications at School" form. This must be accompanied by a medical order, according to Diocesan Medication Policy, before any medications can be given at school.

Does this student have any physical conditions or restrictions which will limit his/her involvement in school activities?

Yes / No. If Yes, explain _____

Is there anything else we should know about your child's health or physical condition? _____

Name of Medical Care Provider _____ Phone _____

Parent/Guardian Signature _____

Date _____

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Physical Examination Form

THIS SECTION TO BE COMPLETED BY MEDICAL CARE PROVIDER

Student's Name _____ Gender ____ Gr ____ DOB _____

Father's Name _____ Mother's Name _____

Physical Examination:

Known Allergies: _____

Height: _____ inches Weight: _____ pounds BP: _____ / _____ Hearing: R _____ L _____

Vision: Uncorrected: B: 20/____ R: 20/____ L: 20/____; Corrected: B: 20/____ R: 20/____ L: 20/____

Eyes _____ Heart _____ Skin _____

Ears _____ Lungs _____ Spine/Neck _____

Nose _____ Abdomen _____ Scoliosis: Neg:____ Pos:____

Teeth _____ Hernia _____ Posture _____

Throat _____ Nervous Sys. _____ Orthopedic _____

Glands _____ Nutrition _____ Genitalia _____

Other (specify) _____

Urinalysis: (if indicated) _____

Hgb: (if indicated) _____

Cocci: Date: _____ Result: _____

TB: Date: _____ Result: _____

| |
|--|
| Immunizations Given Today: _____ _____ _____ |
| Please provide a copy of the updated immunization record. |

Is this student currently receiving any medications? YES / NO If yes, list meds: _____

Does this student have any physical conditions or other restrictions which will limit his/her involvement in a regular school program or school activities? YES / NO If yes, please explain:

I certify that I have on this date examined the above-named student and I have found no medical reason to disqualify him/her from participating in all supervised physical education activities and athletics, with the exception of:

Medical Provider's comments and/or recommendations: _____

Medical Provider's Name (printed) MD DO PA NP

Medical Provider's Signature _____ Date _____ Phone #