

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 _____ DOB _____
Last First M.I.

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 #