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. The physician section must be based on a physical examination that occurred no more than 12 months before the first day of school for the upcoming year.

For participation in sports, this physical examination is required each year: to be completed on or after MAY 20, 2026.

(*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 Zip code

MOTHER'S NAME: _____ TELEPHONE: _____ _____
First Middle Last Home/Cell Work

FATHER'S NAME: _____ TELEPHONE: _____ _____
First Middle Last Home/Cell 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: ___
(list last seizure and list any prescribed preventative and or rescue medications needed)

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 hereby authorize:

_____**to take my child to:**
NAME OF SCHOOL

_____
PHYSICIAN **ADDRESS** **TELEPHONE #**

_____
HOSPITAL **ADDRESS** **TELEPHONE#**

PARENT / GUARDIAN'S SIGNATURE: _____ **Date:** _____

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:_____
_____

IMMUNIZATION RECORDS OR MEDICAL EXEMPTION FROM VACCINES (yearly) MUST BE SUBMITTED TO SCHOOL: COMPLETED FOR AGE OF STUDENT AND APPROVED IN ORDER TO COMPLETE ENROLLMENT

Immunizations Submitted: Yes ☐ No ☐
Immunizations Approved: Yes ☐ No ☐
Notes:

HEARING SCREEN DATE:

	1st screening		Hearing Screening	2nd screening		1st Vision Screening	2nd Vision Screening
at 25 dB	R	L	at 25 dB	R	L	Distance Acuity:	Distance Acuity:
1000 HZ			1000 Hz			R20/_____ L-20/_____	R-20/_____ L-20/_____
2000 Hz			2000 Hz			Pass_____ Refer_____	Pass_____ Refer_____
4000 Hz			4000 Hz			Fail _____	Fail _____
						Signature:	Signature:

Spinal 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 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) 2/2026