# 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

# DIOCESE OF TUCSON CATHOLIC SCHOOLS

**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: ______________________________________

________________________________________________________________

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

________________________________________ ________________ ______________________
Medical Provider's Signature Date Phone #