The Catholic High School Student Health Questionnaire

Name_____ Age_____ DOB_____ YOG_____

Assessment of Student Health - To be completed by Parent or Legal Guardian

To the best of your knowledge, has your child had any problem with the following? Please check and provide comments if yes.

	YES	NO	Comment		YES	NO	Comment
Allergies: Medicine				Lead Poisoning/Exposure			
Allergies: Food/Seasonal				Learning Problems, Disabilities			
Asthma				Limits on Physical Activity			
Behavioral or Emotional				Meningitis			
Birth Defects				Prematurity			
Bleeding Problems				Problem with Bladder			
Cerebral Palsy				Problem with Bowels			
Dental				Problem with Coughing			
Diabetes				Seizures			
Ear Problems/Deafness				Severe Allergic Reactions			
Eye/Vision Problems				Sickle Cell Disease			
Head Injury				Speech Problems			
Heart Problems				Surgery			
Hospitalizations (when/where)				OTHER			

2. Current Medical Conditions: _____

3. Current Medications: _____

4. Emergency Medications: _____

5. Age Menstruation began: _____

6. Family History of (Circle all that apply): Asthma Diabetes Migraines Epilepsy
Kidney Problems High Blood Pressure

   a. If Yes, note relation to Student: _____

7. Has your daughter ever been diagnosed with a head injury or concussion by a medical professional?

   If YES, How Many? _____ Date of Most Recent Concussion _____

8. Any other relevant information: _____

_____

_____

_____

Parent Name_____ Signature_____ Date_____

The Catholic High School Medical: Physical Examination

To be completed ONLY by Physician/NP/PA

Name_____ Age_____ DOB_____ YOG_____

1. Does the child have a diagnosed medical condition? No ____ YES _____
   _____
2. Is the child on regular medication(s)? No___ YES_____
   _____

3. Does the child have a health condition which may require **EMERGENCY ACTION** while she is at school? (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please **DESCRIBE** and **attach an emergency action plan**.
   No ___ YES_____
   _____

Physical Exam	WNL	ABNL	Area of Concern	Health Area of Concern	YES	NO
Head				Attention Deficit / Hyperactivity		
Eyes				Behavior / Adjustment		
ENT				Development		
Dental				Hearing		
Respiratory				Immunodeficiency		
Cardiac				Lead Exposure / Elevated Lead		
GI / GU				Learning Disabilities / Problems		
Menstrual Cycles				Mobility		
Musculoskeletal/Orthopedic				Nutrition (e.g. Eating disorder)		
Neurological				Physical Illness / Impairment		
Skin				Psychosocial		
Endocrine				Speech / Language		
Psychosocial				Vision		
OTHER				OTHER		

4. Date of most recent **TETANUS** immunization_____ **(Please include copy of immunization record)**

Height:_____ Weight:_____ BP:_____ Pulse:_____ Vision:____/ 20__

Remarks: Please explain any abnormal findings/health concerns or other medical issues that the school health or Athletic Staff should be aware of:

▢ **Cleared** for ALL Physical Activity

▢ **NOT CLEARED** - Reason: _____

_____ _____ _____

Examiner Name (Print or Type) Examiner Signature Date

_____ _____

Address (City, State, Zip) Phone Number