

CENTRAL CATHOLIC HIGH SCHOOL  
HEALTH HISTORY

To be completed by parent

CLASS OF \_\_\_\_\_

Student's Name: \_\_\_\_\_ ID# \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Physician's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_

1. When did your child last see a medical doctor? \_\_\_\_\_

Explain: \_\_\_\_\_

2. Does/Has your child have/had disease(s) that affects the function of the eye, ear, heart, kidney, muscles, lungs, or immune system? YES \_\_\_\_\_ NO \_\_\_\_\_ if "yes" explain: \_\_\_\_\_

3. List any operations, fractures, sprains, or bone dislocations.  
\_\_\_\_\_  
Date or Age \_\_\_\_\_  
\_\_\_\_\_  
Date or Age \_\_\_\_\_  
\_\_\_\_\_  
Date or Age \_\_\_\_\_

4. Has your child ever had any of the following? Please circle Y for YES and N for NO.

a. Asthma/Allergies	Y N	k. Mononucleosis	Y N
b. Fainting/Convulsion	Y N	l. Pneumonia	Y N
c. Heart Murmur/Condition	Y N	m. Hepatitis	Y N
d. Rheumatic Fever	Y N	n. Bronchitis	Y N
e. Kidney Disease or Injury	Y N	o. Head Injury	Y N
f. Heat Stroke/Heat Exhaustion	Y N	p. Concussion	Y N
g. Diabetes	Y N	q. Seizure	Y N
h. Menstrual Problems	Y N	r. Serious Dental Problems	Y N
i. Blood Disorders	Y N	s. Tumors	Y N
j. Arthritis/Joint Tenderness	Y N	t. Bridges/False Teeth	Y N

**HAS YOUR CHILD EVER HAD CHICKENPOX** \_\_\_ YES \_\_\_ NO **WHEN?** \_\_\_\_\_  
**ANY OTHER SERIOUS ILLNESS OR INJURY:** \_\_\_\_\_

PLEASE EXPLAIN ANY YES ANSWERS TO THE ABOVE QUESTIONS: \_\_\_\_\_

5. Does your child take any medication now? \_\_\_\_\_ If so what? \_\_\_\_\_

6. Does your child wear contacts or glasses Yes \_\_\_\_\_ No \_\_\_\_\_

7. Do you know any reason for your child not to participate in sports? \_\_\_\_\_

8. I hereby give permission for my child to participate in \_\_\_\_\_

**PARENTS PLEASE NOTE.....CCHS MUST KNOW WHAT YOUR HOME HEALTH INSURANCE PLAN IS CALLED. \*\*\*\*if no health insurance write none\*\*\*\***

NAME OF PLAN \_\_\_\_\_ POLICY NUMBER \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

**CENTRAL CATHOLIC HIGH SCHOOL  
PHYSICAL EXAMINATION FORM**

To be completed by Provider

STUDENT

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

VACCINE	DATE		VACCINE	DATE		VACCINE	DATE		Chickenpox History		
<b>DTaP/DTP/DT</b>	1		<b>OPV/IPV</b>	1		<b>HIB</b>	1		<b>O check for reliable history of chickenpox</b> - physician interpretation of parent description of chickenpox, - physical diagnosis of chickenpox, or - serological proof of immunity		
	2			2			2				
	3			3			3				
	4			4			4				
	5										
<b>Adult Td</b>	1		<b>MMR</b>	1		<b>Hepatitis B</b>	1		<b>Varivax</b>	1	
	2			2			2			2	
							3				

**Tuberculin test or low risk assessment is required for all new enterers (within 1 year of entry)**

Tb risk factors (exposure, travel to TB countries, foreign born parent): \_\_\_\_\_ Med-High risk \_\_\_\_\_ Low risk  
(check which applies)

PPD date \_\_\_\_\_ PPD reading date \_\_\_\_\_ PPD Results \_\_\_\_\_ mm

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Significant Past Illness/ Injury \_\_\_\_\_

Nutritional Status \_\_\_\_\_

Eyes R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Glasses Y / N Ears R \_\_\_\_\_ L \_\_\_\_\_

Nose \_\_\_\_\_ Mouth \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_

Skin \_\_\_\_\_ Lungs \_\_\_\_\_ Heart \_\_\_\_\_ Genitalia \_\_\_\_\_

Abdomen \_\_\_\_\_ Liver \_\_\_\_\_ Spleen \_\_\_\_\_ Hernias \_\_\_\_\_

Posture/Spine \_\_\_\_\_ Neck \_\_\_\_\_ Musculoskeletal \_\_\_\_\_ Neurological \_\_\_\_\_

Able to participate in Athletics/Sports \_\_\_\_\_ YES \_\_\_\_\_ NO Limits \_\_\_\_\_ YES \_\_\_\_\_ NO

Specific Recommendations for Participation \_\_\_\_\_

**DATE OF EXAM** \_\_\_\_\_ **Provider's Name** \_\_\_\_\_

PLEASE PRINT

**PROVIDER'S SIGNATURE** \_\_\_\_\_