2009 - 2010

ARCHDIOCESE OF ATLANTA
CATHOLIC SCHOOL HEALTH REPORT

This form must be completed by the parent/guardian for each student and returned prior to July 15, 2009.

Child's name: _____ Sex: _____ Birth date: _____ Grade_____
First Middle Last

Address: _____
Street City Zip code

Mother's name: _____ Telephone: _____ _____
Home Work or Cell

Father's name: _____ Telephone: _____ _____
Home Work or Cell

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 up this child 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: ____

_____

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: _____

*****SPECIAL EMERGENCY REFERRAL INSTRUCTIONS*****

In the event of a medical emergency warranting immediate medical care, EMS (911) will be called and parents will be responsible for all incurred expenses.

Parent/Guardian Signature: _____ **Date:** _____