



**Holy Child Academy**  
*(Students entering grades 5 - 8)*

Dear Parent/Guardian:

In order for us to best serve your child, we need your help in ensuring that the records in our school health office are up to date. Please complete this form, have your family doctor fill out the other side, and return the form to the school nurse.

Thank you.

Student: _____	Date of Birth: _____
Address: _____	Home Telephone: _____
Mother/Female Guardian: _____	Father/Male Guardian: _____
Mother's Cell Phone #: _____	Father's Cell Phone #: _____
Work Address: _____	Work Address: _____
Work Phone #: _____	Work Phone #: _____

Emergency Contacts:	<b><i>(This information must be provided)</i></b>	
Name of Contact #1: _____	Name of Contact #2: _____	
Address: _____	Address: _____	
Telephone #: _____	Telephone #: _____	

HISTORY					
	<u>DATE</u>		<u>DATE</u>		<u>CHECK</u>
Anemia		Sickle Cell		Asthma	
Chicken Pox		Heart Disease		Allergy	
Diabetes		Pneumonia		Surgeries	
Seizure		Tuberculosis		Serious Injuries	

ANY SERIOUS ILLNESS OTHER THAN ABOVE       DETAILS IF PERTINENT \_\_\_\_\_

\_\_\_\_\_

Is your child supposed to wear glasses  YES  NO      Does your child wear contact lens?  YES  NO

Please list any allergies your child has: \_\_\_\_\_

Please list any special medication your child is taking: \_\_\_\_\_

Does your child have any physical or emotional condition(s) requiring restriction of his/her participation in physical education or any other school activity? \_\_\_\_YES \_\_\_\_NO If YES, please contact the principal or school nurse at once.

**I hereby give my daughter/son \_\_\_\_\_, entering grade \_\_\_\_\_, permission to participate in interscholastic athletics for the 2014-15 school year. I acknowledge that there are risks involved in sports activities.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**School Health Form / Physician's Certificate**  
**THIS FORM MUST BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Height: _____ Weight: _____ Body Mass Index: _____  Weight Status Category (BMI Percentile): <input type="checkbox"/> Less than 5 <sup>th</sup> <input type="checkbox"/> 5 <sup>th</sup> through 49 <sup>th</sup> <input type="checkbox"/> 50 <sup>th</sup> through 84 <sup>th</sup> <input type="checkbox"/> 85 <sup>th</sup> through 94 <sup>th</sup> <input type="checkbox"/> 95 <sup>th</sup> through 98 <sup>th</sup> <input type="checkbox"/> 99 <sup>th</sup> and higher	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3" style="text-align: right;">Referral</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">Vision – without glasses/contact lenses</td> <td style="text-align: center; padding: 2px;"><b>R</b></td> <td style="text-align: center; padding: 2px;"><b>L</b></td> <td style="width: 20px;"></td> </tr> <tr> <td style="padding: 2px;">Vision – with glasses/contact lenses</td> <td style="text-align: center; padding: 2px;"><b>R</b></td> <td style="text-align: center; padding: 2px;"><b>L</b></td> <td></td> </tr> <tr> <td style="padding: 2px;">Vision – Near Point</td> <td style="text-align: center; padding: 2px;"><b>R</b></td> <td style="text-align: center; padding: 2px;"><b>L</b></td> <td></td> </tr> <tr> <td style="padding: 2px;">Hearing <input type="checkbox"/> Pass 20 db sc both ears or:</td> <td style="text-align: center; padding: 2px;"><b>R</b></td> <td style="text-align: center; padding: 2px;"><b>L</b></td> <td></td> </tr> </tbody> </table>	Referral			Vision – without glasses/contact lenses	<b>R</b>	<b>L</b>		Vision – with glasses/contact lenses	<b>R</b>	<b>L</b>		Vision – Near Point	<b>R</b>	<b>L</b>		Hearing <input type="checkbox"/> Pass 20 db sc both ears or:	<b>R</b>	<b>L</b>	
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Blood Pressure: _____ Nutrition: _____ Teeth and Gums: _____ Glands – Cervical: _____ Heart and Lungs: _____ Orthopedics: Spinal deviation: _____ Genitalia (male): _____	Nervous System: _____ Speech: _____ Tonsils and Throat: _____ Thyroid: _____ Skin: _____ Scoliosis: _____ Feet: _____ Urinalysis (if done): _____
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Does this child have any condition requiring on-going medical care? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If YES, please specify: \_\_\_\_\_

Are there any issues relating to growth, development or nutrition with which his/her teachers should be acquainted?  
 \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If YES, please specify: \_\_\_\_\_

Should any restrictions be placed on this child's participation in physical activities? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If YES, please specify: \_\_\_\_\_

Does this child take any medication (other than vitamins) on a regular basis? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If YES, please specify: \_\_\_\_\_

Are there any other medical issues of which the school should be aware regarding this child? \_\_\_\_\_ YES \_\_\_\_\_ NO  
 If YES, please specify: \_\_\_\_\_

Immunizations:	Date(s) of Administration(s):
1. Polio/OPV	1 _____ 2 _____ 3 _____
	Booster _____
2. DPT/DTAP	1 _____ 2 _____ 3 _____
	Booster _____
Tdap	_____
3. TD	1 _____ 2 _____ 3 _____
4. HbCV /Hib	1 _____ 2 _____
5. Varicella	1 _____ 2 _____
6. PCV (Pevnar)	1 _____ _____ _____ _____
7. Menactra	1 _____
8. M/M/R	1 _____ 2* _____
	OR
	Measles 1 _____ 2* _____
	Mumps 1 _____
	Rubella 1 _____
9. Hepatitis B	1 _____ 2 _____ 3 _____
10. Mantoux	1 _____
	(within 1 Year) (Required for new entrants including the results)
	<i>* Necessary for children born on or after January 1, 1985</i>

Signed: _____	Title: _____
Address: _____	License #: _____
Telephone #: _____	Date of Examination: _____