Holy Child Academy

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: ______________________________
Work Address: ______________________________ Work Address: ______________________________
______________________________ ______________________________

Emergency Contacts: ***(This information must be provided)***
Name of Contact #1: ______________________________ Name of Contact #2: ______________________________
Address: ______________________________ Address: ______________________________
______________________________ ______________________________
Telephone #: ______________________________ Telephone #: ______________________________

HISTORY

	DATE		DATE		CHECK
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.

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):

☐ Less than 5th ☐ 5th through 49th ☐ 50th through 84th

☐85th through 94th ☐ 95th through 98th ☐ 99th and higher

			Referral
Vision – without glasses/contact lenses	R	L	
Vision – with glasses/contact lenses	R	L	
Vision – Near Point	R	L	
Hearing ☐ Pass 20 db sc both ears or:	R	L	

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): ____________________

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 ____
6. PCV (Prevnar) 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)

** Necessary for children born on or after January 1, 1985*

Signed: ______________________________ Title: ______________________________

Address: ______________________________ License #: ______________________________

Telephone #: ______________________________ Date of Examination: ____________________