CATHOLIC SCHOOL HEALTH REPORT **ARCHDIOCESE OF ATLANTA**

A health examination is required for all first time entrants or all new students to the school. This information is required prior to the 1st day of school to be complete. For participation in sports, this physical examination is required each year to be completed after June 1, for the upcoming school year.

(Physical and completed sports packet are required before student can practice and/or play any sport.)

THIS SIDE TO BE COMPLETED BY PARENT/GUARDIAN Entering Grade _____ Year _____

CHILD'S NAME: _____ SEX: M F BIRTHDATE: _____
First Middle Last MM/DD/YYYY

ADDRESS: _____
Street City State Zip Code

MOTHER'S NAME: _____ TELEPHONE: _____
First Middle Last Home Work

_____
Cell

FATHER'S NAME: _____ TELEPHONE: _____
First Middle Last Home Work

_____
Cell

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL:

NAME RELATIONSHIP TELEPHONE NUMBER(S)

1) _____

2) _____

3) _____

PLEASE LIST NAME, RELATIONSHIP, AND TELEPHONE NUMBER(S) OF THOSE WHO MAY PICK UP THIS CHILD FROM THE 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: _____

_____

bb) If yes to b, Epi-Pen prescribed? Yes: _____ No: _____

_____

c) History of head injury, concussion, seizure, etc? Yes: _____ No: _____

_____

d) Any spinal injuries or spinal defects: Yes: _____ No: _____

_____

e) List **all** medications taken on a daily basis:

_____

_____

f) Does your child wear contact lens (eyes) or have any orthodontic appliance in his/her 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:** _____

Form 5320
Rev. 2025

THIS SIDE TO BE COMPLETED BY PHYSICIAN **STUDENT'S NAME (PLEASE PRINT):** _____

RELEVANT HEALTH INFORMATION	PHYSICAL ASSESSMENT	NORMAL	ABNORMAL	NOT EXAMINED
Present Age: yrs. mos.	General appearance			
Height (no shoes): inches (%)	Skin			
Weight (light clothing): lbs. oz. (%)	Head			
Hemoglobin or Hematocrit (opt):	Eyes:			
Urinalysis (opt):	(1) Reflex Test			
	(2) Cover Test			
Other:	Ears			
Blood Pressure:	Nose, Mouth, Pharynx, Teeth			
Pulse / Respiration:	Neck (lymphatic/thyroid)			
	Heart			
	Lungs			
	Abdomen (include hernias)			
	Genitalia			
	Orthopedic			
	Neurologic			

Explanation of Abnormal Findings: _____
_____
_____
_____

Scoliosis Screening: Pass _____ Fail _____ Refer _____ Comments: _____

Patient Health History, Findings, and Recommendations: _____
_____
_____

Physical Activity: Restricted or Unrestricted (circle one)
Note special concerns regarding participation in physical education, athletics, or sports for the child: _____
_____
_____

I have examined the child named on this form, and find that he/she is able to participate in the athletic and physical education programs of the school:

Date: _____ Signature: _____
(stamped signature not accepted)

Please print physician's name and address: _____
(MD / DO or PA or RNP working under the direction of a licensed physician)