The Catholic High School Student Health Questionnaire

Name: _____ Age _____ DOB_____ YOG_____

General Medical History This section to be completed by Parent or Legal Guardian yes no

1. Does your child have any ongoing medical condition currently? If YES, please explain:		
2. Has your child been advised by a physician NOT to participate in any activity (SPORTS) within the last 12 Months? If YES, please describe and give date(s).		
3. To the best of your knowledge, has your child had any problems with the following?		

	Yes	NO	Comment		Yes	No	Comment
Allergies: medicine				Heart Problem			
Allergies: Food				Hernia			
Anaphylaxis				Hospitalization			
Anemia				Learning Disabilities			
Asthma				Meningitis			
Behavior/Emotional				Migraines			
Birth Defects				Nasal Problems			
Bleeding Problems				Physical Disabilities			
Dental				Prematurity			
Diabetes				Seizures			
Ear Problem/Deafness				Sickle Cell Disease			
Eye or Vision Problem				Speech Problems			
GI Problem				Surgery			
GU Problem				Throat			
Head Injury				Other			

4. Age Menstruation began?

	Yes	No
5. Has your child ever had one of the following ?(please circle) Mononucleosis Hepatitis Tuberculosis Other Infectious disease_____		
6. Does your child have any rashes, pressure sores or other skin problems?		
7. Does your child have now or ever had (circle all that apply) Hearing loss Perforated ear drum Different Eye Color Unequal Pupils Sinus Infection Fracture/Broken Nose Loose or broken Teeth/dental Implants		
8. Does your child take medication regularly? If YES, please list and explain for what use:		
9. Does your child take Medication for EMERGENCY Use? If YES, please list:		
Family History		
10. Has anyone in your immediate family had or have: (circle all that apply) Asthma Diabetes Migraines Kidney Problems Epilepsy High Blood Pressure If Yes note relationship to student) _____	Yes	No
11. Has a family member or relative died of heart problems or sudden death before age 50?		
12. Has your child or any member of your family been diagnosed with Marfan's syndrome?		
13. Does your child have SICKLE CELL TRAIT or SICKLE CELL DISEASE? Specify which_____		
Cardiovascular/Respiratory		
14. Has a doctor ever told you that your child has:(circle all that apply) High blood pressure Heart Murmur Enlarged heart Heart Infection High Cholesterol	Yes	No
15. Has your child ever passed out or nearly passed out DURING or AFTER exercise?		
16. Has your child ever had discomfort, pain, pressure, or rapid heartbeat during exercise?		
17. Does your child cough, wheeze, have shortness of breath or use an inhaler or Asthma Medication? Specify		
18. Has your child ever had problems exercising in the heat or been diagnosed with a heat illness? Specify:	Yes	No
Orthopedic		
19. Has your child ever had a muscle strain or sprain, pull, tear, fracture or dislocation? If YES specify body part (s):	Yes	No
20. Has your child had problems with pain, swelling in muscles, tendons, bones or joints? If YES specify body part (s):		
Head and Neck problems	Yes	No
21. Has your child ever been diagnosed with a HEAD INJURY/CONCUSSION by a Medical Professional? If YES How many? _____ Date of most recent Concussion_____		
22. Has your child been hit in the head and been confused or lost memory of lost consciousness?		
23. Has your child ever had a temporary loss of vision after being hit in the head or falling?		
24. Has your child ever had a neck injury?		
25. Has your child ever had numbness, tingling or weakness in her arms or legs after being hit or falling?		

Parent Name: _____ Signature _____ Date _____

The Catholic High School Medical: Physical Examination

TO BE COMPLETED BY PHYSICIAN

Name:_____Age _____ DOB_____ YOG_____

1. Medical Condition: Does the child have a diagnosed medical condition? Yes No
   (e.g. seizures, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, other). Specify: _____
   _____
2. If YES, does the condition require EMERGENCY ACTION while she is at school or athletic activities? Please describe necessary actions or indicators for condition._____
3. SICKLE CELL: Has this individual been tested for SICKLE CELL? Yes No Date:_____
   If yes, please circle the results: Negative Positive Positive Trait
4. Is the child on regular medication? Yes No
   If YES: Name of Medication(s) _____
5. Date of most recent TETANUS immunization:_____ **(Please include copy of Immunization record**)

Height:_____ Weight:_____ BP:_____ Pulse:_____ Vision: ___/20_

General Medical	WNL	Abnormal	Musculoskeletal	WNL	Abnormal	Health Area Concern	WNL	Abnormal
General Appearance			Spine (neck/back)			ADD/ADHA		
Skin			Shoulders			Behavior/Adjustment		
ENT			Arms			Psychosocial		
Dental			Elbows			Development		
Lymph Nodes			Hands/Wrists			Hearing		
Chest			Hips			Immunodeficiency		
Heart/Cardiac			Legs			Elevated Lead		
Lungs			Knees			Learning Disabilities		
Abdomen			Ankles			Nutrition(e.g. Eating disorder)		
Hernias			Feet			GI		
Endocrine			Neurological/Sensory			GU		
Menstrual cycle			Other			Speech/Language		

Remarks: Please explain any abnormal findings/health concerns or other medical issues that the school health or Athletic Staff should be aware of:

☐ Cleared for ALL Physical Activity

I certify that I have on this date examined this student and that on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities.

☐ NOT CLEARED: Reason_____

Note: Should the above individual have any restrictions, a letter from the individual's physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. The Catholic High School of Baltimore reserves the right to make final decisions as to an individual student's status regarding participation in athletic activities for The Catholic High School of Baltimore.

_____ _____ _____

Examiner Name (print or type) Examiner Signature Date

_____ _____

Address Phone Number

_____

City State ZIp