CATHOLIC HEALTH REPORT

Student's Name:		**Grade:**		**Year:**	2023-24
Birthdate:					

Health History

Any known chronic illness: Asthma, Cystic Fibrosis, Diabetes, Heart, etc?	**No** ☐	Yes ☐
If yes, please explain:		
Any known allergies: drug, environmental, food: describe type and reaction?	No ☐	Yes ☐
If yes, please explain:		
History of head injury, concussion, seizures, etc.?	No ☐	Yes ☐
If yes, please explain:		
History of hospitalization or surgery?	No ☐	Yes ☐
If yes, please explain:		
List all medication taken on a daily basis:	No ☐	Yes ☐
Any special concerns regarding participation in PE, athletics or sports for your child?		
If yes, please explain:		
Does your child wear contact lens(eyes) or have any orthodontic appliance in his/her mouth?		

If your child has allergies, asthma, or seizures, we require an updated action plan (filled out by your doctor) each year and a medication permit form to be able to give them the necessary medications. All of these forms are in the "forms" section of SNAP.

Family Physician Name:		Phone:	
Choice of Hospital:			
Any other special information needed about your child:			

*****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 Name (printed) _____

Parent Signature

Date _____