HOLY CROSS MEDICAL HISTORY EVALUATION
PRIMARY SCHOOL GRADES PK-4TH

IMPORTANT: This form must be kept on file with the school. **IMMUNIZATION RECORD MUST ACCOMPANY THIS FORM**

PART I: INFORMATION *(To be filled out by parent or guardian only)*

Name:_____ Grade:_____ School:_____

Age:_____ Date of Birth:_____ Home Telephone #:_____

Social Security Number:_____ Address:_____ City:_____ Zip:_____

Parent's Name:_____ Parent's Employer:_____ Work Telephone #:_____

Insurance Company:_____ Policy #:_____ Family Doctor:_____

PART II: MEDICAL HISTORY *(To be filled out by parent or guardian)*

Has or Does this individual. **Circle & please explain all "yes" answers below**

1.	Have a medical problem or injury since his/her last evaluation?	YES	NO
	Ever not been allowed to participate in sports for a medical reason?	YES	NO
2.	Ever been hospitalized?	YES	NO
	Ever had surgery?	YES	NO
	Have any missing organs? *(eye, kidney, testicle, etc.)*	YES	NO
3.	Presently take any medication?	YES	NO
4.	Have any allergies to medicine or insect bites?	YES	NO
5.	Passed out during or after exercise?	YES	NO
	Been dizzy or passed out during or after exercise?	YES	NO
	Have chest pain during or after exercise?	YES	NO
	Tire more quickly than his/her friends during exercise?	YES	NO
	Have high blood pressure?	YES	NO
	Been told he/she has a heart murmur?	YES	NO
	Have racing of the heart or skipped heartbeats?	YES	NO
	Have a family member that died of heart problems or sudden death before age 50?	YES	NO
6.	Have any skin problems?	YES	NO
7.	Ever had a head or neck injury?	YES	NO
	Ever been knocked out or unconscious?	YES	NO
	Ever had a seizure?	YES	NO
	Ever had a stinger, burner or pinched nerve?	YES	NO
8.	Ever had heat cramps?	YES	NO
	Ever been dizzy or passed out in the heat?	YES	NO
9.	Have trouble with breathing or coughing during or after activity?	YES	NO
10.	Use any special equipment? *(pads, braces, neck rolls, eye guards, kidney belt, etc.)*	YES	NO
11.	Have any problems with vision?	YES	NO
	Wear glasses or contacts?	YES	NO
12.	Ever sprained/strained, dislocated, fractured or had repeated swelling of any bones or joints?	YES	NO

13, Have any medical problems listed below? *(Please check off)*

_____ High Blood Pressure	_____ Rheumatic Fever	_____ Diabetes	_____ Hepatitis
_____ Mononucleosis	_____ Abnormal Bleeding	_____ Tuberculosis	_____ Asthma
_____ Sickle Cell Disease/Trait	_____ Other*(list)* _____		

14. List dates for last: Tetanus Shot:_____ Measles Immunization:_____

Please explain all "yes" answers from above:_____

_____

_____

PART III: SIGNATURES

(You must answer these questions and sign for your child to be examined)

1. The information on the reverse is current and correct to the best of my knowledge ..... YES NO
2. I give my permission for my child to be examined for school-related activities ..... YES NO
3. If, in the judgment of a school representative, the student needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary..... YES NO
4. I recognize the evaluation to be done on my child is a standard pre-participation screening examination, and that no in-depth testing, x-rays, lab work, or cardiac testing will be performed ..... YES NO
5. I understand that if the medical status of my child changes in any significant manner after his physical examination, I will notify his principal of the change immediately ..... YES NO
6. I give my permission for the athletic trainer to release information concerning my child's injuries to the Athletic trainer or Principal of Holy Cross School. ..... YES NO

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____

PART IV: PHYSICAL *(To be filled out by a licensed physician /licensed nurse practitioner in collaboration with doctor or a licensed physician's assistant under the supervision of a licensed physician.*)

Height	**Weight**	**Blood Pressure** /	**Pulse**	
SYSTEM	NORMAL	ABNORMAL	INITIALS	COMMENTS
Heart				
Lung				
Other				
Abdominal				
Genitalia				
Neck				
Shoulder				
Elbow				
Wrist				
Hand				
Back				
Knee				
Ankle				
Foot				
Eye	Right 20/	Left 20/	Corrected?	YES / NO

CLEARANCE: _____A. Cleared

_____B. Cleared after further evaluation/treatment

_____C. Not cleared for: _____Collision _____Contact _____Non-contact

RECOMMENDATIONS: _____

_____

NAME OF MD/NURSE PRACTITIONER: _____ **DATE:** _____

ADDRESS: _____ **TELEPHONE:** _____

SIGNATURE OF MD/NURSE PRACTITIONER: _____

PARENTS ARE REQUIRED BY LAW TO FURNISH THE SCHOOL WITH A VALID, UP-TO-DATE COPY OF THEIR SON'S IMMUNIZATION RECORD. LOUISIANA STATUTE 17:170 MANDATES THAT ALL STUDENTS BE PROPERLY IMMUNIZED IN ORDER TO ATTEND ANY SCHOOL WITHIN THE STATE. THE MINIMUM IMMUNIZATION REQUIREMENTS FOR STUDENTS TO BE ELIGIBLE TO ATTEND AND REMAIN IN SCHOOL ARE SHOWN BELOW *.

State of Louisiana Universal Certificate of Immunizations

Date:_____

Child's Name:_____ **SIIS Patient ID:**_____

Date of Birth: _____ **SSN:** _____

Parent/Guardian:_____

MONTH/DAY/YEAR EACH DOSE WAS GIVEN

Vaccine	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6	Dose 7
DTaP/PTP/DT							
OPV/1PV							
MMR							
Hib							
Hep B – 3 Dose							
Varicella							
Pnemo (PCV7)							
Meningococcal							
HPV							

***School Entry Complete Minimum:** 4-DTP, 3 Oral Polio (last DTP and Polio after 4th birthday), 2-MMR after 1st birthday and, 3 Hep B. It is recommended that a student be given a DT at 14-16 years of age and every 10 years after that. The law does not allow for letters of dissent. However, not letter will be accepted except those signed by the parent or guardian at the school, in the presence of a school official.

**** Daycare Center:** Hib also required

*** Beginning Aug. 2003, Varicella vaccine or history of the disease will be required for school and daycare entry.

**** As a result of Hurricanes Katrina and Rita in 2005, many immunization records were destroyed or lost. Impacted children should be considered up-to-date for enrollment as long as they show proof of having received age-appropriate immunizations.

Varicella History:_____

Physician's Name:_____

Physician's Address:_____ **Telephone:**_____

Signature of Physician:_____ **Date:**_____