SAINT STANISLAUS 2026-2027

Health Form (Medical History)

Completed and Signed by Parent/Guardian

In order for this health form to be valid, it must be dated AFTER April 1, 2026.

Student's Last Name	First Name	Middle	Date of Birth	Grade	RESIDENT DAY

Please answer Yes or No. Give date. Has student ever had or does he have:

	YES	NO	DATE		YES	NO	DATE
Allergies, food, drug, other				Liver disease			
Anemia/bleeding disorders				Meningitis			
Other blood disease				Migraine headaches			
Arthritis				Nervous or mental disease			
Asthma				Pneumonia			
Chicken Pox				Poliomyelitis			
Diabetes				Rheumatic fever			
Diphtheria				Sinus			
Ear Problem/loss of hearing				Skin disease			
Epilepsy				Thyroid trouble			
Hay Fever				Tuberculosis			
Heart Conditions				Ulcer, Stomach or duodenal			
Hernia				Vertigo (dizziness) or fainting spells			
Kidney Disease				Other			

IF YES, OR ANY DISEASE (except usual childhood diseases), GIVE DETAILS: _____

_____

CIRCLE EACH ITEM 'YES' OR 'NO'

1. HAS YOUR SON EVER HAD A HEAD INJURY, HEAT STROKE, HEAT EXHAUSTION OR HEAT CRAMPS? YES or NO
2. HAS YOUR SON EVERY BEEN UNABLE TO TAKE PHYSICAL EDUCATION OR PARTICIPATE IN SPORTS BECAUSE OF HIS HEALTH? YES or NO
3. HAS YOUR SON EVER HAD A SERIOUS INJURY OR OPERATION? YES or NO
4. HAS YOUR SON USED THE SERVICES OF A PSYCHOLOGIST, PSYCHIATRIST OR OTHER MENTAL HEALTH PERSONNEL OR CLINIC? YES or NO

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN: _____

_____

☐ **PLEASE LIST DRUGS TO WHICH YOUR SON IS ALLERGIC**: _____

☐ **DATE OF LAST TETANUS IMMUNIZATION**: _____

Parent's Signature X	**Date (must be AFTER April 1, 2026)**

Health Form (Physical)

Completed and Signed by Physician

Student's Last Name	First Name	Middle	Date of Birth	Grade	RESIDENT DAY

This record is filed with our nurse in the school dispensary.

Height:	Weight:	Pulse:	B/P:	Vision:	right 20/	left 20/

	norm	abnorm	Comments
Heart			
Lungs			
Back & Extremities			
Throat			
Lymph glands			
Thyroid			
Hernia			
Hearing			
Abdomen			
Neurological			
Urinalysis: Sp Gr	Alb	Sugar	Micor

The following is recommended:

Eye refraction:	Audiometer test:
Recommended Medicines:	Special Care/Comments:

I have conducted a limited physical examination of the student named above and within the scope of this examination have found no obvious reason that this student may not participate in the school athletic program.

Physician's Signature X	**Date (must be AFTER April 1, 2026)** X