Department of Catholic Schools
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, Texas 78228
(210) 734-2620 • Fax (210) 734-9112
Hwww.sacatholicschools.org

HEALTH QUESTIONNAIRE

Pupil: _____ Grade: _____ Date of Birth: _____
Last Name First MI

Street Address: _____ City/State: _____ Zip: _____

Father's Name: _____ Phone: _____

Place of Employment: _____ Phone: _____

Mother's Name: _____ Phone: _____

Place of Employment: _____ Phone: _____

Physician: _____ Phone: _____

Hospital Preference: _____

Dentist: _____ Phone: _____

PHYSICAL HISTORY	**YEAR**
Accident-Serious	
Allergy* - Drug/Other	
Asthma*	
Blood Disorder	
Cardiac Disease/Problem	
Chicken Pox (date required)	
Congenital Deformity	
Diabetes	
Hearing Loss	
Hypertension	
Illness – Serious	
Scarlet Fever	
Neurological Disorder	
Otitus Media (Ear Infection)	
Rheumatic Fever	
Seizure Disorder (Epilepsy) **	
Surgery** - Serious	
TB Contact	
Urinary Problem	
Vision Loss	
Daily Medication	
INJURIES	
Head**	
Back**	
OTHER	
COMMENT(S):	

REQUIRED SCREENING

I understand the following screenings will be provided to my child as required: vision, hearing, scoliosis and Acanthosis Nigricans. The school will follow the required screening schedule.

Parent/Guardian Signature: _____ Date: _____

* Please indicate an "M" for moderate or an "S" for severe. ** Details needed, please use COMMENTS section