



# HEALTH FORM 2022-2023

Salesian College Preparatory  
2851 Salesian Avenue, Richmond CA 94804

**The completed Health Form must be presented to the school before the student is allowed to attend class.**

**ALL NEW STUDENTS AND ALL ATHLETES** attending Salesian College Preparatory are required to have a physician's examination and to present verification of their immunization record. California law AB 354 requires that all students entering 9th - 12th grades show proof of an adolescent whooping cough booster shot (called "Tdap").

Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

**HEALTH HISTORY OF STUDENT- TO BE COMPLETED BY PHYSICIAN**

**Please note any current/prior conditions:**

Injuries: _____  Operations: _____	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">_____ Allergies</td> <td style="border: none;">_____ Heart Ailments</td> </tr> <tr> <td style="border: none;">_____ Asthma</td> <td style="border: none;">_____ Hernia</td> </tr> <tr> <td style="border: none;">_____ Concussion</td> <td style="border: none;">_____ Epilepsy</td> </tr> <tr> <td style="border: none;">_____ Deafness</td> <td></td> </tr> </table>	_____ Allergies	_____ Heart Ailments	_____ Asthma	_____ Hernia	_____ Concussion	_____ Epilepsy	_____ Deafness	
_____ Allergies	_____ Heart Ailments								
_____ Asthma	_____ Hernia								
_____ Concussion	_____ Epilepsy								
_____ Deafness									

**DATE EACH DOSE WAS GIVEN**

VACCINE	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
Tdap Booster					
POLIO (OPV)					
DTP and/or DT/Td Or Tetanus & Diphtheria only					
MMR (Measles, Mumps, Rubella)					
Hepatitis B					
COVID-19					

TB Skin Test Result: \_\_\_\_\_ Date: \_\_\_\_\_

Height \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_ Glasses/Contacts: YES NO

**I have examined the above student on this date and have found him/her/they physically fit to attend school and to participate in interscholastic high school sports, including tackle football.**

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Address: \_\_\_\_\_