

St. Joseph School Physical Form

This report should be completed by the physician and returned to school.

Student name	Grade	School
Address		
Date of Birth	Gender	Phone
Parent or Legal Guardian		

History of recent serious illness/injury/surgery <hr/> Allergies/Asthma/Hay Fever <hr/> Current Medication <hr/> Height _____ Weight _____ Blood Pressure _____ Pulse _____ Hemoglobin/Hct _____ Urinalysis: Sp. Gr. _____ Sugar _____ Albumin _____ Micro _____ Visual Acuity: Rt. _____ Lt. _____ Both _____ Hearing Acuity: Rt. _____ Lt. _____	✓ = Normal Describe impairment: Skin _____ EENT _____ Lymph Glands _____ Heart _____ Lungs _____ Abdoman _____ Orthopedic _____ Scoliosis: yes no x-rays treatment _____ Neurological Findings _____ Did you recommend a referral? _____ Full Activity _____ List Restricted Activities _____ <hr/> Recent Immunization Boosters DPT Dt Td Measles Polio _____ Mumps _____ Other _____ Rubella _____ Other _____ TB test _____ <hr/>
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Date of Examination	Signature of Doctor
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Parent Permission to participate in Interscholastic Athletics

**This form must be signed and returned to the school office
before a student will be permitted to practice**

_____ is given my permission to participate in school sports.

Athlete Signature	Parent Signature
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