DIOCESE OF TUCSON CATHOLIC SCHOOLS

Physical Form

THIS SECTION TO BE COMPLETED BY PRIMARY CARE PROVIDER

Student's name _____ Sex _____ Gr _____ DOB _____

Father's name _____ Mother's name _____

Physical examination:
Known allergies: _____
Height: _____ Weight _____ BP: _____
Vision: without glasses: B 20/_____ R 20/_____ L 20/_____
Vision: with glasses: B 20/_____ R 20/_____ L 20/_____
Hearing: R _____ L _____

Eyes _____ Glands _____ Skin _____
Ears _____ Heart _____ Nutrition _____
Nose _____ Lungs _____ Speech _____
Teeth _____ Gums _____ Throat _____
Tonsils _____ Hernia _____ Posture _____
Abdomen _____ Orthopedic _____ Scoliosis : Neg:_____ Pos:_____

Urinalysis: _____

Hgb: _____
Cocci: Date:_____ Res:_____
Tbc: Date:_____ Res:_____

Immunizations Given Today:
_____
_____
_____

Is this student currently receiving any medications? _____ List meds:_____
_____

Does this student have any physical conditions or other restrictions which will limit the student's involvement in a regular school program or school activities?_____
_____

I certify that I have on this date examined the above-named student and I have found no medical reason to disqualify him/her from participating in all supervised physical education activities and athletics with the exception:_____

Care provider's comments and/or recommendations:_____
_____

_____ MD DO PA NP
Print care provider's name

_____ _____ _____
Care provider's signature Date Phone #

- over -

DIOCESE OF TUCSON CATHOLIC SCHOOLS

Health History

THIS SECTION TO BE COMPLETED BY PARENT

Today's date_____ Child's Entering Grade_____

Student's Name_____ DOB_____
Last First M.I.

Known Medication Allergies_____

Known Food Allergies_____

Has your child ever had any of the following?

Condition	Yes, date	No	Condition	Yes, date	No	Condition	Yes, date	No
Allergies (seasonal)			Hearing Problems			Rheumatic Fever		
Anemia			Heart Problems			Scoliosis		
Asthma			Hepatitis			Seizures		
Back Pain			Hernia			Sinus Problems		
Chicken Pox			Hives			Strep Throat		
Concussion			Joint Pain/Arthritis			Stomach Problems		
Diabetes			Kidney Problems			Tuberculosis		
Eczema			Menstrual Cramps			Valley Fever		
Emotional Problems			Migraine Headaches			Vision Problems		
Fainting			Mononucleosis			Other		

	Description	Year	Description	Year
Operations				
Operations				
Sprains				
Fractures				

Does your child wear glasses or contact lenses?_____ Date of last Tetanus Booster_____

If your child is currently under doctor's treatment, please explain and give doctor's name:_____

_____

Medications now taking_____

If medications are to be given at school, complete "Parent Consent for Giving Medications at School" form. This must be on file before any medications can be given at school.

Does this student have any physical conditions or other restrictions which will limit the student's involvement in the school program?_____ Explain_____

_____

Name of Family Physician_____ Phone_____

_____ _____
Parent/Guardian Signature Date

- over -