



DIOCESE OF TUCSON CATHOLIC SCHOOLS

Physical Examination Form

THIS SECTION TO BE FILLED OUT BY PATIENT

Student Name _____ Entering Grade _____
 Date of Birth _____ Address _____
 Father's Name _____ Mother's Name _____

Medical History: Date and/or Comment _____

Allergies _____
 Chicken Pox _____ Heart Condition _____ Tonsillitis _____
 Mumps _____ Rheumatic Fever _____ Diabetes _____
 Whooping Cough _____ Valley Fever _____ Infectious Hepatitis _____
 Asthma/Reactive Airway _____ Measles _____ Tuberculosis or Contact _____
 Convulsive Disorders _____ German Measles _____ Operations _____
 Chest Conditions _____ Scarlet Fever _____ Injury or Accidents _____
 Eye, Ear, Nose _____ Strep Infections _____ Other _____

IMMUNIZATIONS	1	2	3	4	5	6
DTP/DT/Td						
OPV/IPV						
MMR						
Hib						
Hep B						
Varicella Check box if history of disease <input type="checkbox"/>						
Others						

PARENT/GUARDIAN Signature Required _____

THIS SECTION TO BE FILLED OUT BY PHYSICIAN

Height _____ Vision B. _____ Vision B _____
 Weight _____ without R. _____ with R. _____
 B.P. _____ Glasses L. _____ Glasses L. _____
 Eyes _____ Glands _____ Skin _____
 Ears _____ Heart _____ Nutrition _____
 Nose _____ Lungs _____ Speech _____
 Teeth _____ Hernia _____ Urinalysis _____
 Gums _____ Orthopedic _____ Albumin: _____ Sugar: _____
 Throat _____ Scoliosis: Neg: _____ Pos: _____ Hgb: _____
 Tonsils _____ Posture _____ Cocci: Date: _____ Res: _____
 Abdomen _____ Tbc: Date: _____ Res: _____

Physical Education: Regular: _____

Restricted: (indicate) _____

O.K. for athletics? Yes: _____ No: _____

Doctor's Comments and/or Recommendations: _____

Physician's Signature _____ Date of Examination: _____