



**DIOCESE OF TUCSON CATHOLIC SCHOOLS
SPORTS LEAGUE**

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: _____

Immunizations Given Today: _____ _____ _____

Hgb: _____

Cocci: Date: _____ Res: _____

Tbc: Date: _____ Res: _____

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

_____ Date _____ Phone # _____
Care provider's signature



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Health History

THIS SECTION TO BE COMPLETED BY PARENT

Today's date _____ Child's Entering Grade _____

Student's Name _____
Last First M.I. DOB _____

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 _____