IMMACULATE CONCEPTION SCHOOL
PHYSICAL FORM
GRADE 4-6

Name_______________________________________Grade________Age__________

PHYSICAL FORM TO BE COMPLETED BY PHYSICIAN

HEIGHT________	IMMUNIZATION DATES: include: month, day, year
WEIGHT________	DPT/DT______ _______ _______ _______ ______ _______
B.P.____________	POLIO_______ _______ _______ _______ ______ _______
PULSE__________	MMR ________ _______ VARICELLA_________
URINALYSIS________	MEASLES_______ ________HEP. B _______ ______ _______
HEARING___________	MUMPS_________ ________HIB ________ _______ ______
VISION____________	RUBELLA________ ________PPD_______RESULTS_______

Check Normal/Abnormal:

	N	A		N	A		N	A		N	A
NUTRITION	___	___	HEART	___	___	GENITALIA	___	___	ORTHOPEADIC	___	___
HEENT	___	___	LUNGS	___	___	HERNIA	___	___	SKIN	___	___
NECK	___	___	ABDOMEN	___	___	SCOLIOSOS	___	___	NEURO	___	___
OTHER	___	___									

PHYSICIAN

NO_____ 1. In reviewing this student's medical history, is there any physical factor which might affect the student's ability to learn?
If YES, please explain.____

NO_____ 2. In this student's developmental history, are there any factors that might be a problem in school? If YES, please explain.
____

This certifies that __________________________________ is physically qualified to participate in the following categories of competition during the school year 20___ to 20___.

Any unmarked categories indicate disqualification from the particular group of sports activities.

CONTACT/ COLLISION	LIMITED CONTACT/ IMPACT	STRENUOUS NON-CONTACT	NONSTRENUOUS NONCONTACT
Please check:			
_____________	_____________	______________	______________
Field Hockey	Baseball	Crew	Archery
Football	Basketball	Cross-country	Bowling
Ice Hockey	Diving	Track and Field	Golf
Lacrosse	Gymnastics	Swimming	
Soccer	Skiing-Cross country	Tennis	
Wrestling	Handball		
	Skiing- Downhill		
	Softball		
	Volleyball		

____
PHYSICIAN'S NAME

__________________________________ _______________
PHYSICIAN'S SIGNATURE DATE OF EXAM

ADDRESS