Saint Patrick Catholic High School

Physical Examination Form

One copy of this or another type of exam form must be completed and on file for the school year. It will be good for all activities for a maximum of one calendar year from the date of the exam

Student's Legal Name: _____

Last *First* *Middle*

I hereby state that my signature below authorizes the physicians and athletic staff to conduct this screening. I understand this exam is only for athletic or school activity participation purposes. As such I agree not to hold the examining physician or any staff member associated with this screening legally liable for any injuries and/or non-indicated medical conditions which may appear.

_____ _____ _____

Signature of Parent or Legal Guardian Printed Name **Date**

Examination

Height: _____ **Weight:** _____

BP: _____ **Pulse:** _____ **Respiration:** _____

	Normal	Abnormal Findings	Initials
MEDICAL			
Appearance			
Skin			
Heart			
Lungs			
Abdomen			
Hernia			
Other			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Clearance: _____ **Cleared** _____ **Not Cleared** **Reason:** _____

_____

Examining Physician's full printed/stamped name - address - phone/fax numbers

Physician's Statement: **This student is physically able to participate in the above named activity as indicated by this limited physical examination which I have conducted.**

_____ _____

(Examining Physician's Signature) **(Date of Examination)**