ARCHBISHOP CURLEY HIGH SCHOOL

MEDICAL: PHYSICAL EXAMINATION FORM

TO BE COMPLETED BY PHYSICIAN

NAME: _____ **D.O.B.:** _____ **Grade:** _____ **Sport(s):** _____

1. **MEDICAL CONDITION: Does the child have a *diagnosed* medical condition?** **YES** **NO**
   (e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, other). Specify: _____
   _____

2. **If YES does the condition require EMERGENCY ACTION while he/she is at school or athletic activities?** Please describe necessary actions or indicators for condition.
   _____

3. ***SICKLE CELL*: Has this individual been tested for *SICKLE CELL*?** **YES** **NO** Date: _____
   IF YES please indicate the results: ☐NEGATIVE ☐POSITIVE ☐POSITIVE TRAIT

4. **Is the child on regular medication?** **YES** **NO**
   IF YES – Name of Medication(s) - _____

5. **Date of most recent *TETANUS* immunization:** _____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **Vision** ____/ 20__

GENERAL MEDICAL	WNL	Abnormal
General Appearance		
Skin		
E N T		
Dental		
Lymph Nodes		
Chest		
Heart/Cardiac		
Lungs		
Abdomen		
Hernias		
Endrocrine		
Other		

MUSCULOSKELETAL	WNL	Abnormal
Spine (Neck/Back)		
Shoulders		
Arms / Elbow		
Elbows		
Hands/Wrists		
Hips		
Legs		
Knees		
Ankles		
Feet		
Neurological/Sensory		
Other		

HEALTH AREA CONCERN	WNL	Abnormal
ADD / ADHD		
Behavior/Adjustment		
Psycholsocial		
Development		
Hearing		
Immunodeficiency		
Lead Exposure/Elevated Lead		
Learning Disabilities/Problems		
Nutrition		
GI / GU		
Speech/Language		
Other		

REMARKS: (Please explain any abnormal findings/health concerns or other medical issues that the health staff need to be aware of)

☐ **CLEARED FOR ALL PHYSICAL ACTIVITY**

☐ **NOT CLEARED - REASON:** _____

Note, should the above named individual have any restrictions, a letter from the individual's physician must accompany this form explaining any and all medical conditions as well as indicate restrictions and level of participation. Archbishop Curley High School reserves the right to make final decisions as to the above named individual's status regarding participation in interscholastic athletics for Archbishop Curley High School.

I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me, I have found no reason which would make it inadvisable for this student to compete in supervised athletic activities.

_____ _____ _____
Examiner Name (Print or Type) Examiner Signature DATE

_____ _____
Address Street Telephone Number

_____
City State Zip

If the Physician's Assistant or Nurse Practitioner performed exam, please give the Name & Address of collaborating physician/group