

**The Catholic High School Medical: Physical Examination****To be completed ONLY by Physician/NP/PA**

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ YOG \_\_\_\_\_

1. Does the child have a diagnosed medical condition? No \_\_\_\_ YES \_\_\_\_\_  
\_\_\_\_\_
2. Is the child on regular medication(s)? No \_\_\_\_ YES \_\_\_\_\_  
\_\_\_\_\_
3. Does the child have a health condition which may require **EMERGENCY ACTION** while she is at school?  
(e.g., seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If  
yes, please **DESCRIBE** and **attach an emergency action plan**.  
No \_\_\_\_ YES \_\_\_\_\_  
\_\_\_\_\_

| Physical Exam              | WNL | ABNL | Area of Concern | Health Area of Concern            | YES | NO |
|----------------------------|-----|------|-----------------|-----------------------------------|-----|----|
| Head                       |     |      |                 | Attention Deficit / Hyperactivity |     |    |
| Eyes                       |     |      |                 | Behavior / Adjustment             |     |    |
| ENT                        |     |      |                 | Development                       |     |    |
| Dental                     |     |      |                 | Hearing                           |     |    |
| Respiratory                |     |      |                 | Immunodeficiency                  |     |    |
| Cardiac                    |     |      |                 | Lead Exposure / Elevated Lead     |     |    |
| GI / GU                    |     |      |                 | Learning Disabilities / Problems  |     |    |
| Menstrual Cycles           |     |      |                 | Mobility                          |     |    |
| Musculoskeletal/Orthopedic |     |      |                 | Nutrition (e.g. Eating disorder)  |     |    |
| Neurological               |     |      |                 | Physical Illness / Impairment     |     |    |
| Skin                       |     |      |                 | Psychosocial                      |     |    |
| Endocrine                  |     |      |                 | Speech / Language                 |     |    |
| Psychosocial               |     |      |                 | Vision                            |     |    |
| OTHER                      |     |      |                 | OTHER                             |     |    |

4. Date of most recent
- TETANUS**
- immunization \_\_\_\_\_
- (Please include copy of immunization record)**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Vision: \_\_\_\_/20\_\_

**Remarks:** Please explain any abnormal findings/health concerns or other medical issues that the school health or Athletic Staff should be aware of:( ) **Cleared** for ALL Physical Activity( ) **NOT CLEARED** - Reason: \_\_\_\_\_\_\_\_\_\_  
Examiner Name (Print or Type)\_\_\_\_\_  
Examiner Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Address (City, State, Zip)\_\_\_\_\_  
Phone Number