HOLY SPIRIT CATHOLIC SCHOOL PHYSICAL FORM

(to be completed by MD/DO, PA/RNP working under the direction of a licensed physician.)

Student Name _____Grade Entering_____Sex M or F (circle one)

D.O.B. _____Age _____ Height _____Weight _____ BP _____ Pulse _____ Resp _____

Legend: √=Normal X=Abnormal NE=Not Examined

Physical Assessment							
General Appearance		Skin		Head		Eyes	
Nose/Mouth/Pharynx		Ears		Neck		Heart	
Abdomen		Lungs		Genitalia		Orthopedic	
Neurological							

Explanations of Abnormal Findings _____
_____
_____

Immunization Record			**Dates must be recorded in month/day/year.**			
Immunizations	Dose 1	Dose 2	Dose 3	Dose 4	Booster	Booster
DPT/DTaP						
Tdap						
Polio (OPV/IPV)						
MMR						
Hib						
Hepatitis B						
Hepatitis A						
Prevnar						
Varicella						
Meningococcal						

Hearing Screening: R Pass ___ L Pass ____ Fail ___ Recommendations _____

Vision Screening: R20/ _____ L20/ _____ Fail _____ Recommendations _____

Scoliosis Screening: Pass _____ Fail _____ Comments_____
Patient Health History, Findings and Recommendations _____
_____

Current Medications
_____

Only medications which are necessary for the child to remain in school will be given during school hours. A Medication Permission Form signed by the student's physician and parent must be obtained from the school and must be kept in the school clinic. This includes both prescription and non-prescription medications which must be in the original labeled containers. **Please note, whenever possible, administration of medications should take place at home.**

Physical Activity/Sports: Unrestricted _____ Restricted _____ Explanation _____

I have examined the child named on this form and find that he/she is able to participate in athletic programs of the school.
Date: _____

Signature _____
Printed physician name and address
_____