



DIOCESE OF TUCSON CATHOLIC SCHOOLS SPORTS LEAGUE

Physical Form

THIS SECTION TO BE COMPLETED BY PRIMARY CARE PROVIDER

Student's name _____ Sex _____ Gr _____ DOB _____

Father's name _____ Mother's name _____

Physical examination:

Known allergies: _____

Height: _____ Weight _____ BP: _____

Vision: without glasses: B 20/____ R 20/____ L 20/____

Vision: with glasses: B 20/____ R 20/____ L 20/____

Hearing: R _____ L _____

Eyes _____ Glands _____ Skin _____

Ears _____ Heart _____ Nutrition _____

Nose _____ Lungs _____ Speech _____

Teeth _____ Gums _____ Throat _____

Tonsils _____ Hernia _____ Posture _____

Abdomen _____ Orthopedic _____ Scoliosis : Neg:____ Pos:____

Urinalysis: _____

Immunizations Given Today:

Hgb: _____

Cocci: Date: _____ Res: _____

Tbc: Date: _____ Res: _____

Is this student currently receiving any medications? _____ List meds: _____

Does this student have any physical conditions or other restrictions which will limit the student's involvement in a regular school program or school activities? _____

I certify that I have on this date examined the above-named student and I have found no medical reason to disqualify him/her from participating in all supervised physical education activities and athletics with the exception: _____

Care provider's comments and/or recommendations: _____

_____ MD DO PA NP

Care provider's signature _____ Date _____ Phone # _____