

Physical Examination Form

Sunday, 13 August 2006

Santo Nino Regional Catholic School
 23 College Avenue
 Santa Fe, NM 87508

PHYSICAL EXAMINATION RECORD

Student's Name _____ Gender: Male Female DOB _____

The following is to be completed by the parent or guardian:

	YES	NO
Has the student ever had an illness or injury that required a hospital stay?		
...caused 3 or more days of missed school, practice or competition?		
...is related to allergies?		
...required x-rays?		
Does the student take any medication?		
If "yes", name the medication		
Have any members of the student's family under age 50 had a heart attack, heart problem, or died unexpectedly?		
Has the student ever been dizzy or passed out during or after exercise?		
Has the student ever had a concussion?		
Is the student able to run 1/2 mile without stopping?		
Does the student wear eyeglasses or contacts?		
Wear dental bridges, plates, or braces?		
Experienced first menstrual cycle?		
If "yes" at what age?		
Has the student ever had a heart murmur?		
High blood pressure?		
Heart anomaly?		
Does the student have surgically placed tubes in the ear?		
Has the student ever had bleeding tendencies?		
Asthma?		
Diabetes?		
Epilepsy?		
Sickle cell anemia?		
Epilepsy?		
Emotional problems?		
Bone or joint disease?		
Food allergies?		
Other allergies?		
Other chronic illness?		

Please explain "Yes" answers here.

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PHYSICAL EXAMINATION RECORD

Student's Name _____ Date of Exam _____

Height:	Weight:	Pulse:	BP:
Vision:	R Eye:	L Eye	Corrected? Y N
	Normal (WNL)	Abnormal	Remarks
EENT			
Neck			
Cardiovascular			
Chest and Lungs			
Abdomen			
Skin			
Genitalia-hernia (M)			
Musculoskeletal			
ROM, strength, etc.			
Neck			
Spine			
Shoulders			
Arms/hands			
Hips			
Thighs			
Knees			
Ankles			
Feet			
Neurological			
Sexual Maturity			

Are immunizations current? Yes No

If "No", what is needed? _____

Participation Recommendations:

Clinician's Printed Name _____

Clinician's Signature _____

Address _____ Phone _____