

ST. PATRICK CATHOLIC HIGH SCHOOL

Physical Examination Form

Student's Name	Date of Birth	Grade
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A completed physical form must be submitted for the current school year before a student may participate in any athletic program at St. Patrick Catholic High School.

I hereby authorize the physicians and athletic staff to conduct this screening. I understand this exam is for athletic or school activity participation purposes only. As such, I agree not to hold the examining physician or any staff member associated with this screening legally liable for any injuries and/or non-indicated medical conditions which may appear.

Parent/Guardian Signature	Date
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The information below is to be filled out by the physician. Physicians may use this form or attach a copy of their own.

Height	Weight	Blood Pressure	Pulse
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Orthopaedic Exam

	N	A		N	A		N	A
Spine/Neck			Upper Extremity			Lower Extremity		
Cervical			Shoulder			Hip		
Thoracic			Elbow			Knee		
Lumbar			Wrist			Ankle		
			Hand/Fingers			Feet		

General Medical Exam

	N	A		N	A	Comments N = Normal A = Abnormal	
ENT			Lungs				_____
Heart			Abdomen				_____
Skin			Hernia (if needed)				_____

Based on this limited screening, I see no reason why this student may not participate in athletics, or this student needs further evaluation as described above.

Physician Signature	Date
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