All Saints Catholic School
Act Honorably. Live Virtuously. Seek Truth.

PHYSICAL EXAMINATION

(Required annually for all ASCS students)

Name_____DOB_____

Height _____ Weight _____ Blood Pressure _____ Pulse_____

Vision: R 20 / _____ L 20 / _____ w/Correction ____ Hearing: R (Pass/Fail) L (Pass/Fail)
Circle one Circle one

Head/Neck _____Skin/Scalp_____

Mouth/Teeth _____Renal/Urinary_____

Heart & Circulation_____Neurologic_____

Lungs _____Abdomen_____

Orthopedic_____ Scoliosis Screening: Pass_____Fail_____

Acanthosis Nigricans Screening: Pass_____Fail_____

Patient Health History, Findings, and Recommendations: _____

_____

_____

Physical Activity: Restricted or Unrestricted (Please circle)

If restricted, please provide detail:_____

_____

_____

I have examined this student and I have noted any findings that would prevent full participation in the athletic programs at school.

Physician's Printed Name_____Date_____

PHYSICIAN'S SIGNATURE_____Phone _____